



StopPalu President's Malaria Initiative (PMI) Program Component FY 2014 Annual Report

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StopPalu President's Malaria Initiative (PMI) Program Component

FY 2014 Annual Report

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Abbreviations

ACT	artemisinin-based combination therapy
ANC	antenatal care
AOR	Agreement Officer's Representative
APIC	<i>Association pour la Promotion des Initiatives Communautaires</i>
ASM	American Society for Microbiology
BCC	behavior change communication
BSD	Bureau of Strategy and Development
CAM	<i>Club des Amis du Monde</i>
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CENAFOD	<i>Centre Africain de Formation pour le Développement</i>
CHW	community health worker
CJMAD	<i>Comité des Jeunes Mon Avenir D'abord</i>
CRS	Catholic Relief Services
CSH	<i>Comité de Santé et d'Hygiène</i> (Health and Hygiene Committee)
CSO	civil society organization
DCS	<i>Direction Communale de la Santé</i> (Communal Health Directorate)
DMR	director of prefecture micro-projects
DPS	<i>Direction Provinciale de la Santé</i> (Provincial Health Directorate)
DRS	<i>Direction Régionale de la Santé</i> (Regional Health Directorate)
EMMP	Environmental Management and Monitoring Plan
EPI	Expanded Program of Immunization
FY	fiscal year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IDB	Islamic Development Bank
IEC	information, education, and communication
IEE	Initial Environmental Examination
iMAD	Improving Malaria Diagnosis project
IMNCI	Integrated Management of Newborn and Childhood Illnesses program
INAASPO	<i>Initiatives et Actions pour l'Amélioration de la Santé des Populations</i>
IPTp	intermittent preventive treatment of malaria in pregnancy
KAP	knowledge, attitudes, and practices
LLIN	long-lasting insecticide-treated net
LMG	Leadership, Management, and Governance project
M&E	monitoring and evaluation
MCHIP	Maternal and Child Health Integrated Program
MOH	Ministry of Health
MOP	Malaria Operational Plan
MOU	memorandum of understanding
MSF	Doctors without Borders (<i>Médecins Sans Frontières</i>)

NCC	National Coordination Committee
NGO	nongovernmental organization
NIPH	National Institute of Public Health
NMCP	National Malaria Control Program
NMS	National Malaria Strategy
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
PCG	<i>Pharmacie Centrale de Guinée</i> (Central Pharmacy of Guinea)
PMI	President's Malaria Initiative
PMP	Performance Management Plan
PSI	Population Services International
QA/QC	quality assurance/quality control
RBM	Roll Back Malaria
RDT	rapid diagnostic test
SBC	community health services supervisor
SIAPS	Systems for Improved Access to Pharmaceuticals and Services project
SNIS	National Health Information System (<i>Système National de l'Information de la Santé</i>)
SOP	standard operating procedure
STTA	short-term technical assistance
TWG	technical working group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1 Executive Summary

The President's Malaria Initiative (PMI) Program Component (*StopPalu*) is a three-year project (May 2013 through September 2016) with the goal of assisting the Government of Guinea to achieve the PMI target of reducing malaria morbidity and mortality through multiple interventions in prevention, diagnosis and treatment, and capacity building of the Ministry of Health (MOH) and the National Malaria Control Program (NMCP). RTI International is implementing *StopPalu*, supported by sub-partners Jhpiego, the American Society for Microbiology (ASM), and *Centre Africain de Formation pour le Développement* (CENAFOD).

Malaria is the leading communicable disease in Guinea. Although all of the country's 10.9 million people live in areas at risk of malaria, the country can be divided into four main areas of differing malaria endemicity (Figure 1). In 2010/2011, malaria was the leading cause of outpatient visits and health facility admissions of children under five years of age, accounting for 30% of reported outpatient visits, nearly 25% of admissions, and 14% of hospital deaths in public facilities. Malaria was among the five leading causes of inpatient deaths among children under five years of age. The goal of the National Malaria Strategy (NMS) 2013–2017 is to reduce malaria morbidity and mortality by 50% by 2015.

During the period covered by this annual report (October 1, 2013 to September 30, 2014), the project focused primarily on the following:

- organizing the long-lasting insecticide-treated net (LLIN) mass distribution campaign, coordinated by the NMCP, in 14 prefectures covered by the project and in Conakry;
- supporting the NMCP to develop, review, finalize, and disseminate key national malaria control documents and guidelines (National Strategic Plan [NSP] with its associated Monitoring and Evaluation [M&E] Plan, the National Malaria Control Policy, and training manuals on case management and malaria and pregnancy);
- training health facility workers (private and public) and community health workers (CHWs) on malaria prevention, diagnosis, treatment, and monitoring and evaluation;
- organizing the NMCP's self-diagnosis and developing a capacity-building plan based on the findings of the diagnosis;
- supporting routine malaria data collection at the health facility and prefectural levels;
- organizing behavior change communication (BCC) activities through interpersonal communication and mass media outlets. The project also conducted a knowledge, attitudes, and practices (KAP) survey.

The project's activities this year were strongly affected by the Ebola outbreak—the LLIN distribution in Conakry was delayed, and the national-level meeting concerning feedback from the distribution campaign was postponed. It should be noted that MOH staff at all levels are extremely occupied dealing with the Ebola epidemic, and MOH human resources are not being diverted to issues/projects that deal with other diseases. In addition, the prefectures of Coyah, Dubréka, and Forécariah were heavily affected by the epidemic starting in the month of August 2014, which resulted in decreased project activities at the community level (home visits, community case management). Community workers are afraid of being infected, so they have reduced the number of home visits that they conduct. In late September, the NMCP, based on World Health Organization (WHO) recommendations, called for a suspension of rapid diagnostic test (RDT) use at the community level and recommended

presumptive treatment. This recommendation will strongly impact Guinea's ability to continue its progress with malaria diagnosis activities. In response to the epidemic, the project developed a contingency plan, which we continue to update based on the evolution of the Ebola outbreak.

During the fourth and last quarter, the project supported the NMCP to develop and validate the national guide for routine LLIN distribution at the health facility level (though antenatal care [ANC] and Expanded Program of Immunization [EPI] services). The project continued training staff at private and public health facilities as well as CHWs on malaria case management. The project also trained national trainers, and began training for ANC staff, on malaria diagnosis and care during pregnancy. In preparation for the NMCP's national supervision of Guinea's malaria control activities, the project supported the NMCP in revising supervision tools according to new protocols. The main results for this year are the following:

- 13,869 people were trained in LLIN distribution, micro-planning, enumeration, distribution, and net hanging activities and promotion.
- 2,540,409 LLINs were distributed to 717,551 households during the mass distribution campaign.
- 22 Guinean artists were trained on key malaria prevention and treatment messages; they produced the song "*Dormons sous MILDA*" (Let's Sleep under LLINs).
- 58 journalists were trained on delivering malaria control messages.
- The national LLIN routine distribution guide was developed and validated.
- National guidelines on malaria in pregnancy were updated and validated.
- 1,052 health facility staff members were trained on intermittent preventive treatment (IPT).
- 15 national trainers were trained on malaria diagnosis.
- 74 hospital lab technicians were trained on malaria diagnosis (RDT and microscopy).
- Case management protocols and training curricula were updated and validated.
- 680 CHWs were trained/received refresher training on community case management and were equipped with BCC materials and reporting tools.
- 995 health facility staff members (public and private facilities) were trained on updated case management protocols and training curricula.
- 114 Provincial Health Directorate (*Direction Provinciale de la Santé* [DPS])/Communal Health Directorate (*Direction Communale de la Santé* [DCS]) monthly monitoring meetings were supported.
- The Guinea NSP (2013–2017) has been validated and disseminated, as well as the M&E Plan and the National Malaria Control Policy.
- NMCP Diagnosis and Case Management, M&E, and BCC technical working groups (TWGs) are established and functional.
- The protocol between the NMCP and the University of Conakry was signed for the establishment of a vector control and entomology laboratory facility and associated insectary.
- Five sites visits were conducted by the NMCP entomology team at four sentinel sites to capture mosquitoes to facilitate national entomological monitoring and surveillance.

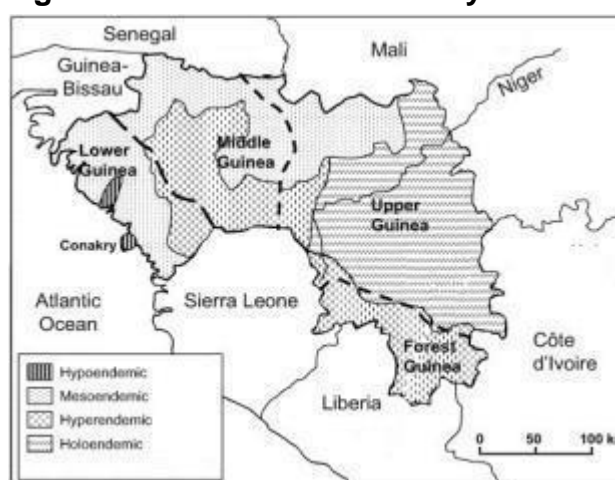
2 Introduction

2.1 Background

2.1.1 Malaria context in Guinea

Malaria is the leading communicable disease in Guinea. Although all of the country's 10.9 million people live in areas at risk of malaria, the country can be divided into four main areas of differing malaria endemicity (Figure 1). In 2010/2011, malaria was the leading cause of outpatient visits and health facility admissions of children under five years of age, accounting for 30% of reported outpatient visits, nearly 25% of admissions, and 14% of hospital deaths in public facilities.¹ Malaria was among the five leading causes of inpatient deaths among children under five years of age. The goal of the National Malaria Strategy (NMS) 2013–2017 is to reduce malaria morbidity and mortality by 50% by 2015. NMS implementation has benefited from two grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (Rounds 2 and 6 and Single Stream Funding: approximately \$50 million) and \$10 million from the President's Malaria Initiative (PMI).

Figure 1: Malaria endemicity in Guinea



2.2 Program Description

2.2.1 Project goal and objectives

The goal of the *StopPalu* project is to assist the Government of Guinea to achieve the PMI target of reducing malaria morbidity and mortality. Main objectives include the following:

1. Improving malaria prevention in support of the NMS
2. Improving diagnostic testing and malaria treatment capacity
3. Enhancing the National Malaria Control Program's (NMCP's) technical capacity to plan, design, manage, and coordinate a comprehensive malaria control program

For each result area, our operational strategy integrates and links the inputs, processes, and systems required for strong results.

2.2.2 Partners

RTI partners for *StopPalu* include the following:

- **Jhpiego:** Jhpiego works to improve malaria outcomes and strengthen the quality of services at facility and community levels, which it will continue and scale up under *StopPalu*.
- **The American Society for Microbiology (ASM):** ASM provides *StopPalu* with evidence-based and context-appropriate approaches to consensus-based diagnostic training and capacity building, monitoring and evaluation (M&E) of laboratory

¹ Mamady, K. and Hu, G. (2011). A step forward for understanding the morbidity burden in Guinea: a national descriptive study. *BMC Public Health* 11:436.

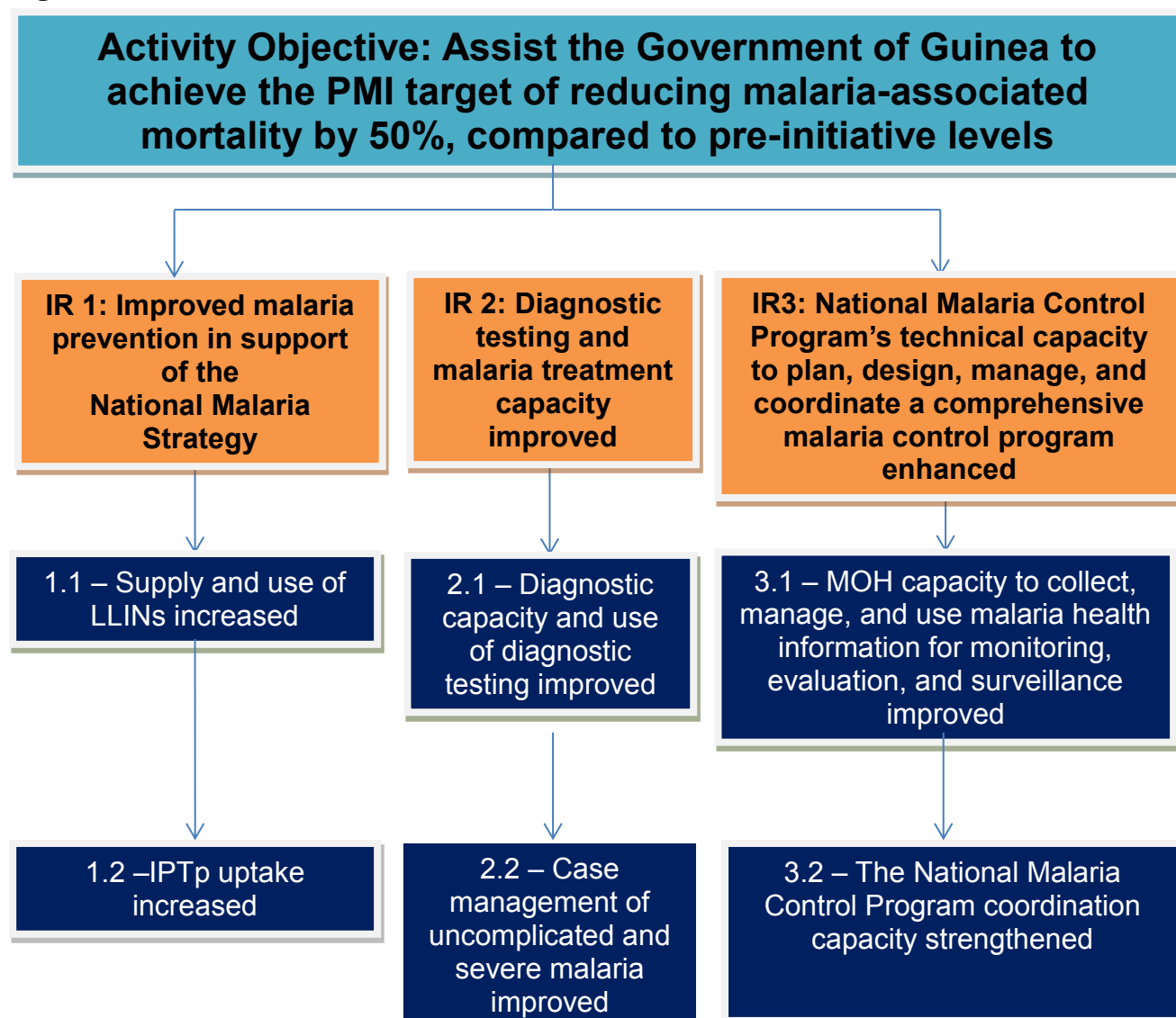
practices and collaborative quality improvement, and country-owned solutions for enhanced performance.

- **Centre Africain de Formation pour le Développement (CENAFOD):** CENAFOD supports the integration of governance aspects in *StopPalu* activities—from promoting better service provision, transparency, and accountability of government partners to helping civil society play its roles more effectively.
- Local partners include four Guinean nongovernmental organizations (NGOs) with demonstrated PMI program results in behavior change communication (BCC) and social mobilization: *Association pour la Promotion des Initiatives Communautaires* (APIC), *Club des Amis du Monde* (CAM), *Comité des Jeunes Mon Avenir D’abord* (CJMAD), and *Initiatives et Actions pour l’Amélioration de la Santé des Populations* (INAASPO).

2.2.3 *StopPalu* results framework

The main objectives of the project as well as the three main results are shown in Figure 2. The four following sections describe the activities carried out for each of these results and project management.

Figure 2: Results framework



3 ACTIVITIES BY RESULT

3.1 Result 1: Improved Malaria Prevention in Support of the NMS

3.1.1 Sub-result 1.1: Supply and use of LLINs increased

■ General Objective

To increase the supply and use of long-lasting insecticide-treated nets (LLINs), both for the 2014 mass campaign and as part of routine distribution, we will prioritize collection and relay of comprehensive commune-level data for effective local, regional, and central LLIN quantification and dissemination; synchronize with information, education, and communication/behavior change communication (IEC/BCC) and advocacy campaigns; and train community health workers (CHWs), mother and child health providers, and local government/civil society structures on LLIN access and use.

During this reporting period, the activities under this result focused on organizing the mass distribution campaign in the PMI zone based on lessons learned from distribution in the GFATM area and supporting the NMCP to develop and validate the national routine LLIN distribution guide. These activities are briefly described below. (Note: Activity numbering refers to the Year 2 Work Plan list of activities.)

■ Specific Activities and Results

Activity 1.1.1.1. Support coordination activities at the central level.

The LLIN national campaign was organized in three phases. Phase 1 of the campaign was organized in May 2013 by Catholic Relief Services (CRS) with funding from the Global Fund in 19 prefectures. Phase 2 was organized by *StopPalu* in November 2013, with funding from PMI, the Islamic Development Bank (IDB), and the Government of Japan/UNICEF. This phase covered the other 14 prefectures. The Phase 3 was organized in May 2014 in five communes of Conakry, with PMI and IDB funding. The distribution strategy in Conakry was two LLINs per household (due to the quantities of LLINs available).

As part of organizing Phases 2 and 3, the project supported the NMCP to hold several working meetings with the National Coordination Committee (NCC). These meetings helped to inform the committee about the different stages of campaign implementation and solicit committee members' opinions to resolve difficulties. These meetings were also instrumental in reviewing and adapting strategies to address weaknesses noted during Phase 1, including the low involvement of authorities at all levels. Drawing on lessons learned from the past, the NCC recommended not only involving authorities and health workers but also empowering health and hygiene committees, as well as neighborhood leaders in Conakry, to participate in the management of the micro-planning process, household enumeration, and distribution and hanging activities. These working meetings enabled the committee to oversee activities in the field. The committee also played an important role in the advocacy meetings for social mobilization in the campaign.

Activity 1.1.1.2. Store LLINs at central level

For the implementation of Phases 2 and 3 of the campaign, *StopPalu* received, stored, and secured 2,609,800 LLINs in four rented warehouses in Conakry. These LLINs were procured and donated by different partners to NMCP: 1,343,150 were purchased by PMI, 985,750 by the IDB, and 280,900 by the Government of Japan through UNICEF.

Activity 1.1.1.3. Develop, pre-test, and duplicate communication materials and support materials for all steps of the mass distribution campaign (enumeration, distribution, and sensitization).

During this reporting period, and in line with the distribution campaign's national communication plan, the project produced many communications materials at each step of the campaign to promote the population's participation and the use of the distributed nets.

The project used the validated training modules, including the social mobilization guide, to train 5,233 enumerators and social mobilization agents for Phases 2 and 3 (3,849 agents for Phase 2 and 1,384 for Phase 3). To harmonize key messages delivered during household visits, the project produced a total of 2,616 copies of a checklist (1,916 for Phase 2 and 700 for Phase 3) with promotion and awareness-raising messages and distributed them to each team. The project also produced visual aids on essential actions for proper use and maintenance of nets, to be shown and discussed during the household visits. These materials were used during enumeration, distribution, and post-distribution awareness building.

Table 1: Number of communication materials produced during household enumeration, Phases 2 and 3

	PHASE 2	PHASE 3
Tee Shirts	4,000	3,505
Caps	4,000	1,265
Bags	4,000	1,126
Banners	176	160

Table 2: Number of communication materials produced during distribution, Phases 2 and 3

	PHASE 2	PHASE 3
Tee Shirts	4,170	3,555
Caps	100	0
Posters	1,000	1,500
Banners	175	260

Due to the Ebola outbreak, the long time between the Phase 3 enumeration and distribution stages was longer than planned. To offset the time lapse, the project increased the number of communication materials to promote population participation in the distribution. The project developed a press book that presented complete information on the campaign for officials, partners, and the media to use during the Phase 3 launch ceremony. The book contained information on the context of malaria in Guinea, the donors and implementing partners involved in the campaign, the campaign strategy, the prefectures where distribution would occur, and the quantities of LLINs that would be distributed, as well as general information on malaria (cause, consequences, prevention, and treatment methods) and key actions to correctly use and maintain LLINs.

With the NMCP, the project printed the validated monitoring and supervision tools for each step of the campaign and distributed them per level of implementation: the distribution sites, the health centers, and the prefectures.

Training for 22 Guineans artists

To increase community participation in the campaign and the regular use of LLINs, the project held a one-day session on October 25, 2013 for 22 well-known Guinean musical artists on key malaria prevention messages. After the training, the artists committed to produce a song on LLIN use. Within two weeks, the artists, with project support, produced a song called “*Dormons sous Milda*” and a video of the artists singing it, as their contribution to the success of the campaign and the fight against malaria in Guinea. The project worked with radio stations throughout the 14 prefectures and in Conakry to broadcast the song.

Training for 58 journalists

During FY 2014, the project trained 58 journalists in three regions covered by the project. During the first one-day session, March 26, 2014, the project trained 24 journalists from public and private media in Conakry on key malaria prevention messages. During the month of May 2014, the project trained 34 journalists in the regions of Boké and Labé. Participants at the training workshops included journalists from public and private radio stations from the 10 prefectures of the two regions. The objective of these workshops was to provide the media staff with all necessary information on how to disseminate appropriate messages to promote healthy behaviors related to malaria control. These trainings also improved media involvement in the fight against malaria.

Activity 1.1.1.4. Conduct cascade trainings of community agents and supervisors (micro-planning, logistics, social mobilization, enumeration, and distribution) for universal distribution campaign.

During FY 2014, the project organized several types of trainings for the two phases of the mass distribution campaign.

Pools of trainers at national, regional, and prefectural levels were trained for each phase. Peace Corps volunteers participated in some of these trainings. During the reporting year, a total of 13,889 people were trained on LLIN distribution, micro-planning, enumeration, distribution, and social mobilization for net hanging and promotion.



Kassopo health center staff filling out their micro-plan form during the training



The chief of the health center presenting the distribution sites covered by his center at the feedback workshop

Training on enumeration and social mobilization

These trainings aimed to allow participants to understand the enumeration process and strategy, the profile and duties of enumeration agents, the key messages for social mobilization, and the supervision strategy. A total of 4141 trainers and agents were trained on enumeration for Phases 2 and 1384 agents for phase 3.

Table 3: Staff trained on enumeration and social mobilization for the LLIN distribution campaign Phase 2 (14 prefectures, November 2013)

Regions	Prefecture	Participants		
		Men	Women	Total
BOKE	Boké	618	113	731
	Boffa	201	30	231
	Gaoual	173	18	191
	Fria	131	18	149
	Koundara	95	34	129
LABE	Labé	448	104	552
	Lélouma	168	30	198
	Mali	261	39	300
	Koubia	117	17	134
	Tougué	146	19	165
	Dinguiraye	168	25	193
KINDIA	Dubréka	326	36	362
	Coyah	196	21	217
	Forécariah	266	31	297
Total		3,314	535	3,849

Table 4: Staff trained on enumeration and social mobilization for the LLIN distribution campaign for Phase 3 (Conakry, April–May 2014)

Region	Commune	Participants		
		Men	Women	Total
Conakry	Dixinn	168	24	192
	Kaloum	76	29	103
	Matam	90	39	129
	Matoto	366	103	469
	Ratoma	395	96	491
TOTAL		1,093	291	1,384

Training on logistics and stock management

The purpose of these trainings was to ensure the proper management of the LLINs in the prefectures and at the distribution sites. The project organized one-day trainings for prefectural warehouse managers. 32 warehouses managers were trained in Phase 2 and 10 managers in Phase 3.

Training on distribution

The objectives of these trainings were to ensure that participants understood the distribution process, the profile and duties of each of the agents at the distribution site, how to organize the distribution site, how to supervise the distribution activity, the levels of supervision, and

how to dispose of the waste. 363 trainers and 2,673 agents were trained on distribution in Phase 2. For Phase 3, 139 trainers and 1,214 agents were trained.

Table 5: Staff trained on distribution for the LLIN distribution campaign in Phase 2

Regions	Prefecture	Participants		
		Men	Women	Total
BOKE	Boké	326	119	445
	Boffa	153	27	180
	Gaoual	143	17	160
	Fria	85	10	95
	Koundara	63	20	83
LABE	Labé	246	102	348
	Lélouma	118	37	155
	Mali	236	15	251
	Koubia	101	13	114
	Tougué	98	24	122
	Dinguiraye	124	14	138
KINDIA	Dubréka	238	29	267
	Coyah	77	18	95
	Forécariah	201	19	220
	Conakry	25	3	28
Total		2,209	464	2,673

Table 6: Staff trained on distribution for the LLIN distribution campaign for Phase 3

Region of Conakry	Communes	Participants		Total
		male	Female	
	Dixinn	134	25	159
	Kaloum	44	16	60
	Matam	64	31	95
	Matoto	344	91	435
	Ratoma	361	104	465
	Total	947	267	1,214

Training on hanging and awareness raising

To ensure the quality of the hanging activity and harmonize the key messages, the project organized one-day sessions in each of the 14 prefectures. These trainings ensured the participants' understanding of how to hang the nets—especially the rectangular ones—how to transform the rectangular nets into round nets, and key messages on washing and repairing nets. A total of 3,763 agents attended these sessions. This activity was conducted only during Phase 2 of the campaign.

Training on micro planning

The objective of the training was to familiarize participants with the micro-planning tools and how to complete them. The micro-planning tools aim to gather detailed information to better plan for the distribution campaign and specific needs in Conakry. A total of 192 participants were trained during the FY 2014 for the campaign in Conakry.

Table 7: Participation in micro-planning training for the Conakry LLIN mass distribution campaign

Region	Commune	Health center staff	Neighborhood leaders	Partner NGO field agents	DMRs/DCS	Total
Conakry	Dixinn	6	21	3	1	31
	Kaloum	10	12	0	2	24
	Matam	2	21	0	1	24
	Matoto	9	38	5	1	53
	Ratoma	9	44	3	4	60
	TOTAL	36	136	11	9	192

Activity 1.1.1.5. Conduct awareness-raising activities to promote the population's acceptance of enumeration (two weeks before enumeration and one week during).

To facilitate people's acceptance of enumeration, awareness-raising activities were conducted to inform the public about the purpose of the enumeration, the importance of keeping the coupons, and the consequences of malaria. We used advocacy meetings with the local officials and community members in each prefecture and commune to explain the process of the campaign and the importance of high participation in the enumeration. These meetings were very helpful in obtaining local authorities' commitment to become involved in the campaign and support the team in the field.

The project also used interpersonal communication activities through NGOs, community-based organizations (CBOs), and Peace Corps volunteers. During enumeration, one person from each two-person team was charged with disseminating key messages on the campaign, the cause of malaria, the importance of LLINs in malaria prevention, and the dangers of malaria.

During Phase 2, the project organized and broadcast 14 roundtable discussions on topics related to the net distribution campaign—in Conakry and all the prefectures except Boffa, Tougué, Dubréka, and Forécariah (where there are no radio stations). These roundtables were very useful, especially in prefectures such as Dinguiraye and Labé, where the population began to think that the door-to-door household enumeration phase was politically related.

The project also produced and broadcast radio and television spots to encourage participation in the enumeration and distribution. A total of 1,904 radio spots and 24 television spots were broadcast during Phase 2. For Phase 3, a total of 120 radio spots and 40 television spots were broadcast over the course of 10 days.

Short messaging service (SMS) messages were sent in collaboration with the mobile phone company Orange, to inform the population about the dates of enumeration and promote the population's participation. After the SMS messages were sent, the number of people visiting the distribution sites increased, especially during Phase 3. During and after the distribution, SMS messages were also sent in the afternoons to remind the population to sleep under the nets, with the slogan "*Toute l'année, toutes les nuits dormons sous MILDA*" (All year long, every night, let's sleep under an LLIN).

Activity 1.1.1.6. Conduct enumerations and voucher distribution in PMI zone for universal distribution and carry out supervision.

For rigorous micro-planning, including all necessary distribution data for a successful universal campaign, exact figures on the population beneficiary were essential. For this reason, the enumeration was a key phase of the campaign.

For Phase 2, enumeration activities began on October 25, 2013 in all 14 prefectures and lasted for 10 days. They were carried out by 3,669 trained enumerators selected by chiefs of health centers and elected officials in each village under the supervision of NGO partners, project staff members, and local officials. The enumeration strategy was a door-to-door visit. The team of enumerators (two agents) visited each household covered by the 130 health centers in the 14 prefectures; counted the number of sleeping spaces; and identified the number of people living in the household, the number of pregnant women, the number of children under five, and the name of the head of the household or its representative. During the visit, the second agent, the social mobilizer, provided key messages on the cause of malaria, the importance of net use in malaria prevention, the phases of the campaign, the dates of the distribution, and the site where the household representative should go to receive the free nets during the distribution phase. Each team of enumerators visited approximately 35 households per day in rural areas and 50 households per day in urban areas, over a 10-day period. However, in the Labé region where the population is widely dispersed, enumerators were unable to achieve this target, and the period was extended for two days. In some prefectures, such as Tougué, Lélouma, and Mali, the enumeration teams were able to contact only three or five households in some villages.

To ensure the quality of the data, the project put a multi-level supervisory system in place.

At the sub prefecture level, each supervisor supervised three groups and was responsible for ensuring that all the households in his supervisory area were visited. In addition, the supervisors were responsible for verifying the data and compiling them at the health facility level. The project also set up prefecture-level supervisors composed of one project staff, three people from the DPS, the DPS Director, the DPS person in charge of disease, and the director of prefecture micro-projects. These people supervised the activity in the entire prefecture. The three DPS supervisors visited households to verify the voucher data and informed the sub prefecture supervisor of any differences found. At the regional level, three people served as supervisors: the DRS Director, the DRS person in charge of disease, and a community representative. They supervised the activity in all the prefectures of the region. The project also recruited independent supervisors who were resource persons from the national partner NGOs (CENAFOD, CJMAD, and INAASPO) and/or trainers on malaria with experience in mass distribution campaigns. This system helped prevent fraud and correct any mistakes that might be made by enumerators.

The main problem the project faced during the enumeration in both phases was in Boffa—some of the consolidated data seemed inconsistent. Although the number of households estimated during the micro-planning was less than the actual number visited during enumeration, the number of LLINs allocated on vouchers increased by more than 3,000. In the health center areas where enumeration teams had assigned these high numbers, some communities averaged eight nets per household, which seemed unusual due to the fact that in the villages it was not easy to find eight sleeping spaces in one household. When the results of the enumeration in the 14 prefectures were presented, the project, in collaboration with the NMCP, decided to send a team composed of *StopPalu* and NMCP staff to revisit some of the households and verify the data. Of the 33 households visited, only 11 had correct information.

After the enumeration phase—and as in the other prefectures—the enumerators were asked to return the unused/unattributed vouchers. The teams in many health centers in Boffa refused. After we compared the number of vouchers sent to the number returned, we found that 40 unused voucher booklets (800 vouchers) were still in the hands of enumerators, despite the

intervention of the DPS and the commune's Secretary General. After our internal inquiry, we understood that this was done with the complicity of some health center chiefs who intended to keep the vouchers and issue them fraudulently to obtain extra LLINs. Given this situation, the project, in collaboration with the NMCP, placed a hold on further campaign activities in Boffa until activities were completed in the other 13 prefectures.

The second round of the enumeration phase was conducted in 8 of the 36 areas of Boffa that had the highest average number of LLINs allocated per household. This activity was conducted December 13–17 and mobilized 84 enumerators. 5,457 households were re-visited. During the first enumeration, 171,957 LLINs were assigned to households in these 8 areas; after the second round, 158,912 LLINs were assigned to the same number of households, a difference of more than 13,000 nets

Table 8: Summary results of enumeration activity in the 14 prefectures

Prefecture	Households Enumerated	Beneficiaries	Children under Five	Pregnant Women	Number of LLINs
Labé	49,908	339,078	61,798	8,150	204,271
Lélouma	24,498	167,011	30,121	5,583	108,100
Mali	37,516	272,417	53,745	8,788	179,842
Tougué	20,812	138,989	30,813	3,605	95,950
Koubia	15,127	107,897	20,939	2,166	63,364
Dinguiraye	27,503	192,521	53,855	9,757	146,100
Fria	17,060	132,340	24,724	2,872	74,195
Boké	83,504	596,235	118,86	21,718	348,884
Boffa	33,066	277,826	59,984	8,533	159,150
Gaoual	21,360	188,478	39,105	5,169	113,127
Koundara	19,286	226,572	29,268	3,023	79,027
Forécariah	34,825	348,724	129,63	81,709	188,556
Dubréka	52,197	494,775	14,142	84,959	221,122
Coyah	38,949	302,502	48,654	9,600	146,050
TOTAL	475,611	3,785,365	715,67	255,62	2,127,738

For Phase 3, enumeration activities in Conakry began on March 22, 2014 in all five communes and lasted for 14 days. They were carried out by 1,328 trained enumerators selected by health center heads and elected officials in each neighborhood (*quartier/secteur*) under the supervision of NGO partners, project and NMCP staff, Ministry of Decentralization staff, and local officials. The enumeration strategy was the same as in Phase 2.

Table 9: Summary results of enumeration activity in the 5 communes

Communes	No. of households	No. of beneficiaries	No. of pregnant women	No. of children under 5	No. of LLINs
Dixinn	40,330	186,368	4,433	31,055	66,929
Kaloum	15,752	90,589	2,436	16,081	25,733
Matam	24,903	143,536	3,868	26,699	41,745
Matoto	116,500	645,697	17,028	125,886	206,711
Ratoma	126,705	638,122	22,087	112,496	230,297
TOTAL	324,190	1,704,312	49,852	312,217	571,415

Activity 1.1.1.7. Conduct communication, BCC, and advocacy activities at the community level on malaria, the LLIN distribution campaign, and correct use and maintenance of LLINs.

To facilitate the acceptance of and participation in the distribution, awareness-raising activities were conducted to inform the public about the distribution process, the location of distribution sites, the importance of bed nets, and how to use and maintain the nets.

Before, during, and after the Phase 2 distribution, the project organized 14 roundtable discussions to inform the population about the distribution strategy, LLIN use in malaria prevention, and the donors and implementing partners. (See Activity 1.1.1.5 for details.)

SMS messages were sent in collaboration with Orange, a local mobile telephone operator, to inform the population on the distribution dates and to promote their participation. (See Activity 1.1.1.5 for details.)

For Phase 3 of the campaign, before the distribution activity, the project organized a series of advocacy meetings in each of Conakry's five communes to inform the population about the distribution strategy, LLIN use in malaria prevention, and the donors and implementing partners. (See Activity 1.1.1.5 for details.)

For the Phase 3 distribution, the project produced a radio and a television spot that promoted people's participation in the distribution. The radio spot was broadcast 140 times and the television spot 42 times.

Three days after the distribution started, we realized that the number of households coming to the distribution sites was decreasing. We decided to use cars with public-address systems (*sono*) to drive around the neighborhoods and encourage people to come to the distribution sites to receive their nets. This activity was very successful and helped increase the number of people visiting the sites.

Other proposed solutions were related to communication activities, such as conducting home visits and organizing roundtable discussions to promote the distribution calendar and the importance of coming to the sites. In many neighborhoods, the teams also worked with local officials and religious leaders to inform the population at mosques and in the markets. We also used a strategy of door-to-door visits to invite and convince people to go to distribution sites to receive their nets. These visits were conducted by NGO facilitators and distribution agents

Activity 1.1.1.8. Transport and store LLINs at the distribution points (via prefectures, health centers).

For the transport of LLINs from Conakry to the prefectures and distribution sites, the project developed a logistics plan based on the micro-planning data. The plan determined the quantities of LLINs needed per prefecture and per site. Given the number of LLINs and the low storage capacity of health facilities, *StopPalu* worked with local officials, particularly the mayors, to identify warehouses that met the safety measures to store the LLINs. The project prioritized transporting and pre-positioning LLINs to the locations most difficult to access. *StopPalu* selected a transport company using a competitive process and worked with the selected company to ensure health and safety measures for both transport and storage. The transfer of the LLINs from the prefecture warehouses to the distribution sites was very challenging—in many prefectures, members of the transporters' union, informed of the campaign, maintained uniformly high prices (especially in Labé region and the Dinguiraye prefecture). Another issue was the bad roads in some prefectures such as Mali, Tougué, and Boké. Many carriers refused to go to these sites. However, it is important to note that in some

prefectures such as Boké, Dubréka, and Koubia, local officials became involved and helped organize transportation, in which case the project applied the same management tools to ensure proper monitoring of the LLINs. After the distribution phase was completed, the project faced the issue of transporting the remaining undistributed LLINs back from the distribution sites to the prefectures.

For Phase 3 of the campaign, the project used the enumeration data and developed a logistics plan for the transport of LLINs from the project's two central warehouses to the communal warehouses and distribution sites. The plan determined the quantities of LLINs needed per commune and per site. Given the number of LLINs and the low storage capacity at distribution sites, *StopPalu* worked with local officials, particularly the mayors, to identify warehouses that met security requirements to store the LLINs. These seven communal warehouses, including security services, were provided by the mayors at no cost to the project.

For the transport and the storage of LLINs in Conakry, the project faced four major problems. The first problem was that many distribution sites did not have enough places to store the LLINs. The second problem involved scheduling appointments with the neighborhood leaders. The third problem was the transport of the distribution team and the LLINs to islands. The fourth problem occurred after we transported the LLINs to all the distribution sites. Six neighborhood leaders were fired by the governor. Therefore we had to get the LLINs back and transport them to the new neighborhood leaders' houses. This was not an easy task; it took an entire day to convince the former leaders to turn the nets over to the project. In Conakry, most of the distribution sites were located in the neighborhood leaders' houses, which is one of the reasons we wanted to change the distribution sites.

Activity 1.1.1.9. Distribute LLINs to the population with collaboration of health centers, Health and Hygiene Committees (CSHs), civil society organizations (CSOs), women's associations, and NGO partners.

Following the distribution strategy defined by the NCC, *StopPalu* used fixed distribution sites to distribute 2,062,688 LLINs in the 14 prefectures during a period of almost 10 days. Heads of households received LLINs at distribution sites, presenting their vouchers on a one-LLIN-per-sleeping-space basis. Based on the results of micro-planning and enumeration, the project established 369 distribution sites. It is important to mention that the LLINs were provided without the cellophane bags to reduce the risk of beneficiaries trying to sell them post-distribution and also to ensure proper waste disposal. Waste disposal was carried out in the presence of the subprefecture supervisor to confirm proper disposal.

The distribution activities were launched on November 20 by a national launching ceremony hosted by the Dubréka prefecture. The activities were organized by the project in collaboration with the NMCP and UNICEF. The Minister of Health and the Minister of Communication, representing the Guinean Government, presided over the launch ceremony. Notable attendees also included the Kindia Region Governor, the Deputy Chiefs of Mission from the US Embassy and the Japanese Embassy, the USAID Health team leader, the PMI Senior Advisor in Guinea, and representatives from international and national NGOs working in Guinea.

The launch ceremony was used as an opportunity to mobilize the population of the city of Dubréka, authorities at regional and local levels, and regional and prefectural services in the Kindia administrative region. Many local health professionals, students, women's groups, religious leaders, and elders were in attendance.

The artists who had composed the song entitled "Let's sleep under LLINs" performed it for the first time at the launch ceremony, inspiring many of the guests to dance to the song. The ceremony also featured various speeches by the Mayor of the Dubréka Municipality, the Governor of Kindia, and the US and Japanese Deputy Chiefs of Mission.

For the distribution phase, the project used a supervisory system at each level as for the other phases.

At the end of the five-day distribution, following data compilation, the teams found that some issued vouchers had not been served. At the request of the teams, the project decided to add three to four more distribution days, depending on the prefectures, to allow the maximum number of households to receive their LLINs.

Table 10 presents the results of the distribution activities in the 14 prefectures.

Table 10: Results of the distribution activities in the 14 prefectures

Prefecture	Households enumerated	Households served	Number of LLINs received	Number of LLINs distributed	Remaining number of LLINs	Coverage (%)
Labé	49,908	46,104	204,271	197,274	6,997	92.38
Lélouma	24,498	23,071	108,100	100,364	7,736	94.18
Mali	37,516	37,345	179,842	162,790	17,052	99.54
Tougué	20,812	19,469	95,950	88,484	7,466	93.55
Koubia	15,127	13,825	63,364	60,526	2,838	91.39
Dinguiraye	27,512	25,614	146,100	146,100	0	93.10
Fria	17,060	16,255	74,195	73,290	905	95.28
Boké	83,504	81,799	348,884	346,113	2,771	97.96
Boffa	33,066	29,772	158,769	145,497	13,272	90.04
Gaoual	21,360	20,969	113,127	113,007	120	98.17
Koundara	19,286	18,285	79,027	78,402	625	94.81
Forécariah	34,825	33,289	188,556	184,860	3,696	95.59
Dubréka	52,197	49,317	221,122	220,377	745	94.48
Coyah	38,949	36,087	146,050	144,500	1,550	92.65
TOTAL	475,620	451,201	2,127,357	2,061,584	65,773	94.87

For the Phase 3 distribution, *StopPalu* used fixed distribution sites to distribute LLINs in the five communes of Conakry over a period of six days. In Conakry, the waste disposal strategy was different from the strategy used during distribution in the prefectures. All the waste (cellophane bags) was incinerated at hospitals using high-temperature incinerators. The project worked with the MOH's Public Hygiene Division, the NMCP, and the National Hospital of Donka to ensure the incineration was properly conducted. The distribution activities began in Conakry's five communes on May 27, 2014. Because of the Ebola epidemic and because MOH representatives were not available, the project and the NMCP decided not to have an official launch ceremony.

During the campaign in Conakry, we noticed a decrease in the number of households visiting the sites after the second day. After many discussions, we found that some households had lost their vouchers. This can be explained by the long period between the enumeration and the distribution (2 months). Many people thought that the distribution would no longer happen. To solve this problem, we informed the distribution agents to ask these people to bring their ID card and to use their personal information (name of the person, name of his/her

mother, the name of the neighborhood, etc.) to find the original of their vouchers. Thanks to this strategy, the agents were able to serve many households that had lost their vouchers.

Another problem we faced was that many people rejected the NETPROTECTOR nets because of their size (small, seemingly for children's beds) but also because of the materials the nets were made of. During the distribution, some people returned these nets and we had to replace them with the circular nets or rectangular nets from other manufacturers.

To solve the problem regarding the shape of the nets and increase the use of the distributed LLINs, the project requested and obtained USAID approval to use the 100,000 nets that had been set aside for routine distribution for the campaign instead, and to use the rectangular nets for routine distribution. The reasons were that in urban areas, people prefer the circular nets, and also it is easier to explain to beneficiaries how to transform rectangular nets into circular ones during health facility visits than during a mass distribution campaign.

After the five distribution days, we discovered that some beneficiaries did not receive their nets. The project team, in collaboration with the NMCP and the local authorities, decided to add a sixth day (a Sunday). This enabled heads of households who work during the week to have an opportunity to go to sites and receive their nets.

After all six distribution days, we were able to distribute 478,825 LLINs to 266,350 households. The coverage rate was 83% of households enumerated. This rate is lower than what was achieved in the 14 prefectures (94%). Two major factors explain these results:

1. The long period between the enumeration and the distribution—some households had lost their vouchers, other households had moved.
2. The Ebola epidemic—some people thought that being in a crowd during the distribution could be a risk for getting Ebola.

Table 11: Results of the distribution activities in Conakry

Communes	Number of households enumerated	Number of households served	Number of LLINs distributed	Coverage rate	Number of LLINs sent by communes	Number of remaining LLINs
Dixinn	40,330	32,967	57,343	81.74%	66,929	9,586
Kaloum	15,771	12,913	20,809	81.88%	26,688	5,879
Matam	24,903	22,492	37,455	90.32%	41,750	4,295
Matoto	116,500	98,256	176,548	84.34%	206,587	30,039
Ratoma	126,805	99,722	186,670	78.64%	230,960	44,290
Total	324,190	266,350	478,825	83%	572,914	94,089

Activity 1.1.1.10. Support supervision activities.

Supervision was a key activity for the campaign's success. As mentioned in the different activities above, for both phases the project supported close supervision to help ensure the quality of services (enumeration, distribution, hanging and messaging) provided by field agents, identify issues, and assist in the search for solutions. The project used a supervisory system at each level of implementation: subprefecture, prefecture, regional, and national. We also involved different actors in the supervisory system: community representatives, NGO partners, health center chiefs, DPS, DRS, project staff, NMCP, and MOH representatives.

All the supervisors were trained and equipped with adequate tools for effective supervision. The project also developed and used tools that help ensure effective supervision of all supervisors. Supervision was conducted at health facilities, distribution points, and

community levels. These different levels of supervision helped correct errors and mistakes, improve the quality of data, and also reduce the risk of fraud.

Activity 1.1.1.11. Conduct hanging activities and post-campaign awareness-raising.

Following the distribution of LLINs in the 14 prefectures, the same persons who conducted the household visits for enumeration also revisited these households to encourage people to use and maintain nets properly.² The project provided them with training and necessary tools to help the community properly hang their nets and raise awareness on LLIN use.

This activity was one of the campaign's successes and very useful for the proper use of LLINs. During the activity, most of the families that were visited had kept the LLINs under their mattresses or beds or in suitcases, for no specific reason. This activity helped the households hang the nets, especially the rectangular ones. It was also an opportunity to remind them of the importance of using the nets and to deliver key messages on how to use the nets correctly and maintain them (washing or repairs as needed). During this activity, the project was able to visit and help 346,232 households to hang their nets.

After the hanging phase, one agent said to a staff member, "Doctor, we have done many activities during this campaign, but this hanging phase was essential since we would have no result without this activity." The activity was generally well accepted by communities, although in the Labé prefecture, an LLIN vendor used a private radio station to discourage people from using the free nets. When the project and the DRS broadcast a roundtable discussion that also accepted comments from the public to explain the process of the activity and its importance, the problem was solved.

For the mass distribution campaign in Conakry, due to the limited number of LLINs to be distributed per household (maximum 2), it was not cost-efficient to conduct hanging activities. However, we focused more on BCC activities to promote the effective use of nets. The NGO facilitators were asked to focus their mass communication activities in Conakry on promoting hanging of nets and proper and regular use of nets. The facilitators were trained on how to transform the rectangular nets into circular ones.

Activity 1.1.1.13. Organize post-campaign feedback workshops.

In order to share the results of the campaign's best practices and lessons learned, and to make recommendations, the project organized 14 workshops at each of the prefectures. These meetings were conducted under the leadership of the DPS. The workshops helped share the results of the campaign and obtain feedback from all the actors who participated in the campaign. However due to the Ebola outbreak, we were not able to organize the national feedback workshop.

Activity 3. Plan and implement IEC/BCC campaigns for LLIN uptake and proper use.

StopPalu carried out the following:

Activity 1.1.3.1. Support NMCP IEC/BCC formative research and production of data-based materials.

During the Quarter 3 of FY 2014, the project worked with the NMCP to select an agency (Diagnostic Sarl) to conduct the knowledge, attitudes, and practices (KAP) survey. This survey aims to gather information on the perceptions, knowledge levels, behaviors, social and economic barriers, and determinants of target populations, especially aspects affecting

² In some cases, ineffective or corrupt enumerators had been replaced, but this was rare.

pregnant women and young children, to understand factors underlying low uptake and use of LLINs and malaria services. The project team worked with the NMCP and the selected agency to develop a protocol and questionnaire. The survey started during the month of September 2014. We expect to receive the results during the month of November. After the survey, *StopPalu* will support the translation of findings into revised/updated IEC/BCC tools and materials for CHWs and health facility teams, improved mass media malaria prevention packages, more targeted community outreach, and supervision and monitoring of LLIN IEC/BCC efforts.

Activity 1.1.3.2. Plan and implement IEC/BCC campaigns based on formative research findings on four themes in malaria control (LLIN, intermittent preventive treatment [IPT], case management, hygiene).

During the month of August 2014, *StopPalu* supported the NMCP's establishment of a BCC technical working group (TWG). During the last quarter of the reporting year, *StopPalu* continued to broadcast radio and TV spots on regular and correct LLIN use and early care-seeking. The project also worked with the BCC TWG to produce posters on free malaria commodities at the health facility and community levels. The BCC TWG, based on the findings of the formative research, will integrate changes into the national guidelines and training manuals to be used by all partners.

Home visits conducted by project-trained CHWs

After receiving training, each CHW conducted home visits and delivered messages on the importance of regular and correct use of LLINs and early care-seeking. During the visits, they verified if the nets received by the households were hung and helped hang the nets if they were not.

The CHWs also explained the signs of malaria and promoted early care-seeking practices as soon as malaria symptoms are noticed. The CHWs tested all cases of fever with rapid diagnostic tests (RDTs), treated the positive cases using artemisinin-based combination therapy (ACT, anti-malarial treatment), and referred severe cases to a health center.

During FY 2014, the 680 trained CHWs in the regions of Boké, Conakry, Kindia, and Labé conducted 75,606 home visits and were able to reach 425,748 people, among whom 233,504 were women (see Table 12).

Table 12: Number of home visits conducted by CHWs in FY 2014

Training	Year 2				TOTAL
	Oct 2013 – Sep 2014				
	Q1	Q2	Q3	Q4	
Prefectures	Oct 2013 – Dec 2013	Jan 2014 – Mar 2014	Apr 2014 – Jun 2014	Jul 2014 – Sep 2014	
Boffa	0	744	2,038	1,920	4,702
Boké	0	504	4,308	3,839	8,651
Coyah	0	720	2,174	2,014	4,908
Conakry				1,336	1,336
Dinguiraye	0		3,483	2,880	6,363
Dubréka	0	949	4,288	3,283	8,520
Forécariah	0	928	5,030	3,993	9,951
Fria	0	204	1,323	1,281	2,808
Gaoual	0	452	1,843	1,944	4,239

Training	Year 2				TOTAL
	Oct 2013 – Sep 2014				
Prefectures	Q1	Q2	Q3	Q4	
	Oct 2013 – Dec 2013	Jan 2014 – Mar 2014	Apr 2014 – Jun 2014	Jul 2014 – Sep 2014	
Koubia	0	0	1,944	2,112	4,056
Koundara	0	0	904	1,680	2,584
Labé	0	0	1,368	2,541	3,909
Lélouma	0	0	3,297	3,816	7,113
Mali	0	0		933	933
Tougué	0	0	2,149	3,384	5,533
Total		4,501	34,149	36,956	75,606

Table 13: Number of people reached by the CHWs in FY 2014

Training	Year 2 Oct 2013 – Sep 2014				TOTAL
Prefectures	Q1	Q2	Q3	Q4	
	Oct 2013 – Dec 2013	Jan 2014 – Mar 2014	Apr 2014 – Jun 2014	Jul 2014 – Sep 2014	
Boffa	0	3,463	13,075	6,560	23,098
Boké	0	4,181	27,851	23,854	55,886
Conakry				7,306	7,306
Coyah	0	5,623	14,775	13,207	33,605
Dinguiraye	0		24,926	19,859	44,785
Dubréka	0	6,318	25,765	18,431	50,514
Forécariah	0	5,927	30,833	23,025	59,785
Fria	0	1,276	7,106	7,255	15,637
Gaoual	0	1,991	11,564	13,649	27,204
Koubia	0	0	8,441	9,283	17,724
Koundara	0	0	9,387	7,245	16,632
Labé	0	0	5,613	16,275	21,888
Lélouma	0	0	12,782	11,111	23,893
Mali	0	0		9,759	9,759
Tougué	0	0	6,466	11,566	18,032
Total		28,779	198,584	198,385	425,748

However due to the Ebola outbreak, the number of home visits in many prefectures decreased during the last quarter. Please see Tables 14 and 15.

Table 14: Detail of home visits conducted by CHWs in Quarter 3 in the prefectures affected by Ebola

Prefectures	Number of home visits conducted	Number of people reached		
		Male	Female	Total
Boffa	2,038	5,806	7,269	13,075
Boké	4,308	13,169	14,682	27,851
Coyah	2,174	6,497	8,278	14,775
Dubréka	4,288	11,496	14,269	25,765
Forécariah	5,030	13,813	17,020	30,833
Fria	1,323	3,279	3,827	7,106
Total	19,161	54,060	65,345	119,405

Table 15: Detail of home visits conducted by CHWs in Quarter 4 in the prefectures affected by Ebola

Prefectures	Number of home visits conducted	Number of people reached		
		Male	Female	Total
Boffa	1,920	2,640	3,920	6,560
Boké	3,839	11,013	12,841	23,854
Coyah	2,014	5,721	7,486	13,207
Dubréka	3,283	8,215	10,216	18,431
Forécariah	3,993	10,644	12,381	23,025
Fria	1,281	3,344	3,911	7,255
Total	16,330	41,577	50,755	92,332

Discussion groups facilitated by the project's NGO partners

To increase people's level of knowledge on malaria and promote the practice of healthy behaviors related to malaria prevention and treatment, the NGO facilitators conducted group discussions in the regions of Boké, Conakry, and Kindia (see Tables 16 and 17). These discussions took place in health centers and public places such as soccer fields, market places, hairdressing salons, and sewing salons. During FY 2014, 5,876 group discussions were held reaching 69,505 people (41,221 women). The messages focused on promoting regular and correct use of LLINs and early care-seeking, especially for pregnant women and children under five.

Table 16: Number of group discussions facilitated by project-trained field agents in FY 2014

Groups discussions	Year 2 Oct 2013 – Sep 2014				TOTAL
	Q1 Oct 2013 – Dec 2013	Q2 Jan 2014 – Mar 2014	Q3 Apr 2014 – Jun 2014	Q4 Jul 2014 – Sep 2014	
Prefectures					
Boffa	0	0	118	48	166
Boké	0	98	134	102	334
Conakry			1,454	2,600	4,054
Coyah	0	32	100	60	192
Dubréka	0		155	123	278
Forécariah	0	32	209	142	383
Fria	0	27	63	43	133
Gaoual	0	12	123	62	197
Koundara	0		105	34	139
Total		201	2,461	3,214	5,876

Table 17: Number of people reached through the group discussions facilitated by project-trained field agents in FY 2014

People reached	Year 2 Oct 2013 – Sep 2014				TOTAL
	Q1 Oct 2013 – Dec 2013	Q2 Jan 2014 – Mar 2014	Q3 Apr 2014 – Jun 2014	Q4 Jul 2014 – Sep 2014	
Prefectures					
Boffa	0	0	3,451	1,994	5,445
Boké	0	2,259	2,780	2,481	7,520
Conakry			16,164	15,611	31,775
Coyah	0	648	1,466	1,309	3,423
Dubréka	0	439	1,728	1,723	3,890
Forécariah	0	374	2,206	1,926	4,506
Fria	0	174	1,386	631	2,191
Gaoual	0	0	1,430	966	2,396
Koundara	0	0	5,649	2,710	8,359
Total		3,894	36,260	29,351	69,505

Production and broadcast of two radio and television spots to promote the use of LLINs

To increase people's acceptance of regular and correct use of distributed LLINs and in addition to interpersonal communication activities conducted by CHWs and NGO facilitators, *StopPalu* produced and disseminated two radio and television spots. During the reporting year, there were 4,102 radio broadcasts and 409 television broadcasts of the two spots. During this year, the project also organized 18 interactive radio programs and 2 roundtable discussions that were broadcast. These programs helped open discussions with beneficiaries regarding barriers and opportunities for the practices of some health behaviors such as the use of LLINs, early care-seeking for malaria symptoms, and keeping ANC appointments. We also discussed the gratuity of malaria services and products.

Activity 1.1.3.3. Advocacy/BCC/Governance: Strengthen the capacities of community leaders and members of the CSHs on advocacy.

To increase community participation in malaria control activities and improve collaboration between the health center staff and communities, the project reinforced the capacity of community-based CSH members on advocacy techniques and supported them on advocacy planning. During Quarter 2 of the reporting year, the project trained 105 CSH members in the prefectures of Boké, Forécariah, Koubia Labé, and Tougué on advocacy techniques; supported the development of advocacy planning; and monitored their progress. This training helped increase community participation in malaria control activities and improve collaboration between the health center staff and communities. The specific objectives of the training were as follows:

- Explain the general concept of advocacy
- Initiate the design of an advocacy objective
- Share information on advocacy planning and develop a budget for its implementation
- Simulate the development and presentation of an advocacy message to help participants identify and implement at least one advocacy activity

At the end of the training, each CSH identified several advocacy topics and developed an action plan to implement activities centered on their topics. The project team and NGO partners monitored the implementation of these activities during the following quarter.

During Quarter 3, *StopPalu* organized a series of trainings for CSH members, local elected officials, and CBO members on the fight against corruption and on participatory monitoring of public services in Boké, Forécariah, and Labé.

The three workshops were attended by 92 participants, including 11 women. The main objective was to strengthen practices against corruption and encourage citizen control of public services, to bring about positive changes in the management of public affairs for the benefit of communities.

Table 18: Number of CSH members, elected officials, and CBO members trained in the fight against corruption and in participatory monitoring of public services, per prefecture

Prefectures	Number of CSH members trained	Number of elected officials trained	Number of CBO members trained	Total
Boffa	3	0	0	3
Boké	8	3	3	14
Coyah	6	2	4	12
Dubréka	8	0	4	12
Forécariah	4	6	1	11
Fria	4	1	0	5
Gaoual	2	2	1	5
Koubia	2	1	1	4
Koundara	7	2	1	10
Labé	3	1	0	4
Lélouma	2	1	1	4
Mali	2	1	1	4
Tougué	2	1	1	4
Total	53	21	18	92

Training of operational staff of NGO partners on modules (fight against corruption and social audit, advocacy, and internal governance of organizations)

In June and September, to improve the capacity of the NGOs partners' facilitators, the project trained 120 people, including 36 women, on three governance topics: advocacy, internal governance of organizations, fight against corruption and social audit.

During the trainings, the trainers emphasized the fact that facilitators should support CSHs and CBOs in the following:

- Strengthening and improving the management of health centers through a better collaboration between CSH members, health workers, local government officials, managers of *Services Techniques Déconcentrés*, members of CSOs/CBOs, etc.
- Strengthening transparency and community involvement in the health centers' management of drugs, equipment/materials, and activities.
- Raising awareness and mobilizing people around the health centers.
- Organizing advocacy actions for the implementation of the community's major priorities in terms of improving their health.
- Monitoring and inspecting public services (performed by citizens) for better health services.
- Posting the costs and fees for services and drugs.
- Organizing community meetings around common priorities.
- Finding means to motivate CHWs.
- Reporting and sharing information.

The training was supported by the distribution of jobs aids and the accountability of NGO partners to maximize the impact of the project through the transfer of competences to and close monitoring of CBOs.

Activity 1.1.3.4. Advocacy/BCC/Governance: Initiate and sustain advocacy for inclusion of the health component, such as malaria, in municipal budgets.

During the reporting period, *StopPalu*, through its NGOs partners, supported and monitored the implementation of 18 CSH advocacy actions. Among these 18 actions, 6 succeeded and 12 are ongoing. The 6 successes are the following:

- The renovation of the health center of Diari in the prefecture of Labé;
- The rehabilitation and renovation of latrines of the Kounsounta health post;
- Obtaining beds and mattresses for the health post of Kiriah;
- Electrification of the health post Tambaya and all three in the prefecture of Coyah;
- Getting an office for the CSH of the urban health center of Forécariah;
- Renovation of the roof of the main building of the Dixinn health center, the treatment room, and the laboratory building; repainting of all the health center buildings.

Activity 1.1.3.5. Train CSHs in the management of health centers (using the validated manual developed by the Directorate for Prevention and Community Health).

During Quarter 2 of FY 2014, the project trained 105 CSH members on their roles and responsibilities in terms of health center management. The workshops reinforced CSH members' capacity, to enable them to assume their roles and responsibilities in order to increase community mobilization to improve the healthcare system.

Specific training topics were the following:

- Review of the principles of primary health care, the country's decentralization policy, and local development
- Community empowerment
- Mission, organization, and operation of the health center
- How to manage resources
- Participatory monitoring and supervision
- Promotion of health for behavior change

At the end of the training, the project encouraged the participants to attend and participate in the monthly meetings held at the health center to help them better understand the results and the challenges that health centers face. The project encouraged them to inform communities of the key points of these meetings. Since these trainings, the CSH members are more involved in health center management. They participate in the monthly meetings, implement some advocacy meetings in Conakry, and conduct awareness-raising activities regarding malaria control.

Table 19: Number of CSH members trained on health center management, by prefecture

Prefectures	Number of CSH members trained
Koubia	18
Labé	54
Lélouma	33
TOTAL	105

Activity 4. Provide focused support to increase LLIN availability at ANC service sites.

Activity 1.1.4.2. Support the NMCP, the Safe Motherhood and the EPI programs to develop a strategy and plan for routine distribution through EPI services.

In accordance with the new national policy and to maintain universal coverage of LLIN levels, in September 2014, *StopPalu* supported the NMCP to organize a national workshop to finalize and validate the national guide for a routine LLIN distribution strategy through public-sector health facilities. The workshop was attended by many partners involved in malaria control activities in Guinea: the Integrated Management of Newborn and Childhood Illnesses (IMNCI) program, EPI, WHO, UNICEF, *Pharmacie Centrale de Guinée* (PCG), PMI, the US Centers for Disease Control and Prevention (CDC), etc. A chief of health center and an ANC staff also attended the workshop. During the two days, the participants reviewed the draft proposed by *StopPalu* and the NMCP, then amended and validated the guide. The guide defines the target population, the distribution strategy, the logistic management, key messages to deliver during the distribution, and M&E tools to be used. The participants agreed that the routine distribution will be done through both ANC and EPI services if there are enough LLINs available. After the validation of the guide, *StopPalu*, CRS, and NMCP worked on the distribution plan for LLINs in all the health centers of the country. This document will be presented during the next meeting of the vector control TWG.

Activity 1.1.4.3. Organize routine LLIN distribution. The project will supervise routine LLIN distribution and advocate for and support the availability of LLINs in ANC service sites.

After the validation of the national routine distribution guide, *StopPalu* developed an implementation plan for the routine distribution, including production of distribution tools, updating of training manuals, training of trainers, training of health center staff, and transport of nets to the health centers. We expect to begin the routine distribution in early December 2014.

Specific Challenges and Measures Used/Planned to Overcome Them

The transport of LLINs to the health centers and close monitoring to be sure that nets are delivered to beneficiaries are the big challenges of the routine distribution. To reduce these challenges, *StopPalu* will intensify communication activities within communities by insisting on free net distribution and also encourage DPS to perform regular supervision, especially during the first months of implementation.

3.1.2 Sub-result 1.2: IPTp uptake increased

■ General Objective

To increase uptake of intermittent preventive treatment of malaria in pregnancy (IPTp), *StopPalu* implemented the following activities:

Activity 1.2.1.1. Update/develop management tools and job aids for the prevention and treatment of malaria during pregnancy and for infants and children according to the NMS and the latest WHO recommendations.

In July 2014, *StopPalu* and Maternal and Child Health Integrated Program (MCHIP) supported the NMCP to organize a workshop with all stakeholders to revise the Guinea malaria in pregnancy guidance according to the WHO latest recommendations. During the meeting, the participants updated the training manuals and protocol for malaria prevention during pregnancy.

Activity 1.2.2.2. Train/update ANC staff and CHWs on the prevention of malaria in pregnancy, and on referral of malaria cases during pregnancy.

During the reporting year, *StopPalu* trained 995 chiefs of health centers, heads of health posts, and staff from private facilities on IPT using the revised malaria case management training manual. The training manual integrates RDT use, case management of simple and severe malaria cases, IPTp, and BCC.

The project also trained 680 CHWs to deliver targeted messages on ANC (LLIN use, sanitation, early care-seeking) and IPTp. These messages are integrated into the CHW training manual. The CHWs were encouraged to verify during home visits if pregnant women are keeping their ANC appointments, if they are receiving sulfadoxine pyrimethamine after the thirteenth week, if they sleep under a net, and if they seek early care in case of fever. The CHWs were equipped with a story board with key messages.

During the last quarter of FY 2014, the project trained 18 national ANC staff trainers and 39 ANC staff from Conakry (one per health facility) on malaria in pregnancy using the revised manual.

Activity 1.2.4.3. Advocate for the presence of a community health services supervisor (SBC) at the district team level.

The MOH nominated an SBC in each prefecture to improve the coordination of community health activities. The project involved these SBCs in all CHW training and supervision. However, the project noted that the SBCs do not yet have a clear understanding of their job. The project planned to work with the Division of Prevention and Community Health to develop a job description for this position and to orient the new SBCs on their roles. However due to the Ebola outbreak, the Division team was too busy and they could not work on this document. We will continue to follow up with the Division.

Activity 1.2.4.4. Strengthen the relationship between health centers and CHWs through monthly supportive supervision, together with outreach strategies and monthly coordination meetings.

To improve the relationship between health facilities and communities (CHWs and CSHs), during the reporting period, *StopPalu*, through its NGOs partners, supported the organization of monthly monitoring and coordination meetings in the health centers in the regions of Boké, Conakry, and Kindia. Please see Activity 3.1.4.1.

Activity 1.2.4.5. Equip CHWs with IEC materials and data collection tools.

To help CHWs perform their duties better, *StopPalu*, through its NGO partners, provided 680 trained CHWs with IEC materials and data collection tools. Each CHW received bags, story boards, monthly report sheets, home visit monitoring forms, and notebooks to record their daily activities. They are provided with reporting materials on a monthly basis.

Challenges and Specific Measures Used/Planned to Overcome Them

Stock-out of commodities and ensuring that the ANC staff are respecting the direct observation treatment present problems in improving IPT services. To overcome these challenges, *StopPalu* regional teams conduct regular supervision but also support DPS and DRS supervision.

3.2 Result 2: Diagnostic Testing and Malaria Treatment Capacity Improved

3.2.1 Sub-result 2.1: Diagnostic capacity and use of diagnostic testing improved

■ General Objective

To improve diagnostic capacity and use of diagnostic testing, our strategy integrates updated malaria diagnostic policies with standards-based, quality-assured laboratory and community diagnostic capacity building, with tailored training for the National Institute of Public Health/National Public Health Laboratory (NIPH/NPHL), hospital laboratory staff, and CHWs. We will also work with supply chain strengthening programs to mitigate shortages of diagnostic commodities, as well as advocate at national level and in multilateral donor forums for adequate RDT procurement.

■ Specific Activities and Results

Activity 2.1.1.2. Develop/update diagnostic policy guidelines, operations plans, training modules, and standard operating procedures.

During Quarter 1 of FY 2014, *StopPalu* worked with MalariaCare and the Malaria Diagnosis and Case Management TWG to revise and validate standard operating procedures (SOPs) and a diagnosis supervision checklist, ensuring consistency with international standards for

malaria diagnostics, and to spearhead adoption of diagnostic quality assurance/quality control (QA/QC) in laboratories and at the community level.

These activities were conducted during two meetings of the Diagnosis and Case Management TWG. The specific objectives were to revise and validate five SOPs and the supervision checklist. The SOPs describe the steps to obtain reliable results.

The following SOPs were validated:

1. Use and maintenance of the optical microscope
2. Assurance and quality control: Drop Thick, Thin Smear, and RDTs in the biological diagnosis of malaria
3. Malaria rapid test diagnosis
4. Biosafety of the medical analysis laboratory
5. Use, coloring, interpretation of Drop Thick and Thin Smears

These SOPs were produced and disseminated in the health facilities after health facility staff were trained on malaria diagnosis.

Activity 2.1.1.3. Develop training strategy and plan for laboratory technicians and CHWs.

Based on the outcomes of the health facility survey (reference activity 2.1.2.1), *StopPalu* worked closely with the Diagnosis and Case Management TWG on the training strategy and plan for rollout of customized trainings for laboratory technicians and CHWs. *StopPalu* trainings focused on more practice with less theory. The training plan targeted all hospitals and *Centre Medico Communal* in the PMI zone and a few health centers that have lab technicians and high numbers of patients.

Activity 2.1.2.1. Conduct malaria diagnosis capacity assessment to evaluate the current quality of diagnostic services.

During Quarter 2 of FY 2014, *StopPalu* with the NMCP, supported by an international consultant, and utilizing a customized assessment tool, conducted detailed malaria diagnosis assessments of 19 facilities in PMI prefectures.

Eight aspects of the laboratory structure and function were assessed and scored:

1. Physical structure
2. Personnel performance
3. Microscope and equipment
4. Supplies for microscopy
5. Reagents for microscopy
6. RDT supplies
7. Reporting
8. Level of ability in performing diagnostic tests for malaria



Unsafe working conditions in an assessed lab



Inadequate staining station in an assessed lab

Key findings: laboratory assessment general results

- The structure of the malaria laboratory system in Guinea ranges across the NIPH, university hospital centers, prefectural and general hospitals within cities and towns, health centers in smaller towns and villages, and health posts in rural communities. Private laboratories are mostly located in urban areas.
- Data management is elementary. Patient information is recorded in the hospital/laboratory register and retained there. There is no regular transmission of information to a central hub or to the MOH.
- With one exception, all 19 laboratories visited were ill-equipped, unsanitary, cramped, and an unsafe working environment for staff and patients. In almost all of the laboratories, the assessment found an accumulation of used or contaminated material, improper storage, retention of dilapidated equipment, and inadequate disposal of laboratory and clinical waste.
- Most facilities lacked functional microscopes, and microscopy is limited because the country does not have regular supplies of electricity—in most areas, electricity is available only for a few hours during the day or night.
- Most laboratories have adequate numbers of staff, but personnel are poorly trained and supervised, and they lack the necessary expertise for reliable and timely malaria diagnosis.
- Testing algorithms and SOPs were outdated, unsuitable, or (most commonly) absent.
- The principal training institution, the NIPH, does not have the resources, expertise, or materials for training. The institute does have a large and adequate classroom, but that is used for storage and would require refurbishing and equipping with microscopes, audiovisual equipment, training aids, and an electricity supply before it could be used for training.
- There are no quality management systems in place.
- There is no M&E plan in place and no indicators identified for laboratory activities.

Recommendations from the assessment

- The assessment found that laboratory diagnosis of malaria in Guinea needs more than improvement. It must be implemented anew, with intensive training and retraining, and provision of laboratory resources. If training is not followed by immediate laboratory application, the lessons learned will be quickly forgotten or incorrectly applied. All trained personnel must be supervised at regular intervals to ensure that

SOPs are invariably used and that basic quality control becomes a regular laboratory procedure.

- A training facility; staff; training microscopes; supplies; reagents; and training, reference, and laboratory aids should be available and in place before training is implemented.
- Training aids must be simple and direct; practical exercises are more efficient than classroom lectures; technicians or health workers who use diagnostic tests must be assured of regular supplies and supervision. More careful attention must be given to potential trainees to ensure that those who will be using the tests have the necessary visual and manual skills to do so; this will be of greater concern in rural environments with volunteer CHWs.
- For microscopy training, a screening and testing procedure should be used to ensure that only candidates who will actually implement their training will be accepted. Administrative or senior staff should not be allowed to use the training experience for professional advancement. Training should also be provided to personnel who will be able to implement their training immediately, otherwise the training experience will be quickly forgotten.
- Laboratories must be supplied with tested, reliable equipment and reagents. For consistent results, reagents such as Giemsa stain should come from one trusted commercial site or be made by a competent laboratory within the public health system.
- All training manuals, SOPs, bench aids, references, and materials should be standardized. An M&E mechanism must be instituted with indicators that are readily accessible. At this time, the relevant authorities should begin identifying and compiling a register of potential candidates for training as diagnostic experts. It is inefficient and costly to have sporadic training conducted by different organizations. Technicians have complained about being given conflicting instructions and methodologies and being subjected to repeated evaluations with no measurable improvement to their services.
- Initially, training should begin with RDT use for rapid dissemination and utilization throughout the country. Cascade training (where one person trains 10 others who go on to train 10 others each) is not recommended—this has never been shown to work in practice. Instead, training should be done consistently by this group of identified experts, who should train another cadre of experts within each region. These regional experts will be responsible for continuous training, supervision, and quality assurance. Their responsibility will be to train technicians and health workers, not to train trainers.
- Supervision is critical to ensure quality of diagnostic services.
- Regular provision of standardized SOPs, bench aids, supplies, and reagents that have been inspected for quality is vital. Keep everything simple.
- Training in microscopy should be conducted only when microscopes, reagents, and supplies are available for personnel being trained. (Solar-panels may be necessary for microscopy if regular electricity is not available.)
- An intensive two-week training in microscopic diagnosis and RDTs should be conducted, focusing on practice rather than theory.
- Laboratory personnel need to be motivated—rapid, reliable laboratory diagnosis will not be provided without adequate compensation and recognition.

Activity 2.1.3.1. Build diagnostic capacity for NIPH/NPHL staff to administer malaria microscopy and RDT training events to lower-level facilities' laboratory technicians and CHWs.

Training of pool of trainers on malaria diagnosis by microscopy and RDT:

Based on the recommendations of the assessment, to foster ownership for quality laboratory and RDT service delivery and ensure sustainability of good practices, *StopPalu* trained a select pool of 15 national laboratory technicians to serve as local trainers. The 15 trainers participated during two weeks (April 7–18, 2014) in an intensive training course on the diagnosis of malaria by microscopy and RDT. Eight of the trainees were laboratory chiefs, and all had received previous training from the Improving Malaria Diagnosis project (iMAD) in Guinea. The training was conducted by an international consultant assisted by a national consultant. It covered both technical and teaching skills for quality-assured diagnostics for malaria microscopy and RDTs. The training was focused in strengthening practical skills with limited theoretical sessions. After the training, six trainers were selected to roll out trainings to laboratory technicians at lower-level facilities and CHWs. The other nine trainees are working in their health facilities. These nine are not yet qualified to be trainers, but they have improved their competences and capacities in malaria diagnosis.

After the training, participants were asked to list their concerns and problems. These were almost exclusively the absence or inadequacy of equipment, supplies, SOPs, bench aids, reference materials, consumables, and reagents for diagnosis; lack of electricity; poor communication between clinician and laboratory; and little training or supervision. To solve some of these concerns, the project worked with the NMCP to provide microscopes to all the laboratories that had trained staff, and supplies were purchased by PMI to enable them to perform correct malaria diagnosis according to the training they received. The project also conducted a joint supervision activity with MalariaCare to monitor both clinicians' and lab technicians' performances.

Training of laboratory technicians:

After the training of trainers, during the last quarter of the reporting year, *StopPalu* used the six selected trainers to organize five training workshops on malaria diagnosis with both microscopy and RDTs. These trainings helped trained 75 lab technicians—17 from Boké, 29 from Conakry, 11 from Kindia and 18 from Labé,



Training of Lab technicians of the region of Boké on malaria diagnosis in September 2014

Organize three joint supervision activities with MalariaCare

During the reporting period, to supervise malaria diagnosis and treatment services in the regional and national hospitals of the country, *StopPalu* and MalariaCare, in collaboration with the NMCP, conducted three joint supervision activities for both diagnosis and treatment

services. To harmonize the supervision strategies and tools, during the first supervision activity the supervisors were trained for two days. During the training, the supervision checklist was reviewed and discussed. At the end of the training, the participants were divided into supervisory teams to supervise the targeted health facilities. Nine regional and national hospitals benefited from these supervisions. The objective of the supervision was to evaluate the performance of the hospital staff on malaria diagnosis and treatment.

Specific objectives were:

- Review adequacy of human resources
- Review laboratory materials and equipment
- Verify the availability of malaria national documents
- Verify internal and external QA/QC processes
- Verify data used for quarterly report on malaria diagnosis
- Observe staff perform microscopy diagnosis and an RDT
- Perform on-the-job training as needed
- Identify problems and make recommendations to resolve them

Each supervision visit started with a small briefing with the laboratory staff on the purpose of our presence in their respective health facility. The questionnaire was used to identify human resources, equipment, supplies, and laboratory consumables. For internal quality assurance, supervisors chose ten slides that they gave to the lab technicians for reading. After their readings, the slides were reviewed by supervisors to verify the validity.

The problems identified include the following:

- Parasite species not always listed in the register
- Slides poorly prepared
- Immersion oil of poor quality
- The age of the patients not mentioned in the register

The joint supervision activity with MalariaCare covered the country and showed good results in PMI zones. However, we also noted some problems, in particular in the two national hospitals of Donka and Ignace Deen, and regional hospitals of Mamou and Kankan. These facilities need more training and closer supervision.

■ **Specific Challenges and Measures Used/Planned to Overcome Them**

The Ebola outbreak will have a major impact on malaria diagnostics, with a decrease in use of RDTs for malaria diagnosis at the community level. In the prefectures not affected by the outbreak, stock-outs of commodities and supervision remain a challenge in ensuring the quality of malaria diagnosis. To reduce the risk, the project will support facilities to send information on their commodities consumption to the NMCP and to order commodities in time to meet their needs.

3.2.2 Sub-result 2.2: Case management of uncomplicated and severe malaria improved

■ **General Objective**

To improve clinical case management of uncomplicated and severe malaria, we will focus on quality-assured training for current and new health staff on standards-based malaria case management, while also strengthening wrap-around inputs and processes critical to treatment

quality and impact: reliable supplies of drugs and testing commodities, supportive supervision of health staff and CHWs, community involvement in service delivery and monitoring, and effective data collection and reporting.

■ Specific Activities and Results

Activity 2. Design and implement a comprehensive case management training plan tailored for each tier of the service continuum.

During Quarter 2 of FY 2014, *StopPalu*, in collaboration with the NMCP, developed a training plan for each tier of the malaria control service continuum in the 14 prefectures and the 5 communes of Conakry. The training plan describes the profile of the trainers and the trainees, the timeframe of each training, the number of trainers to be trained per prefecture, and the number of people to be trained per prefecture for each training topic. It also defines the number of training sessions per prefecture and the number of participants per session

Activity 2.2.1.1. Review/update case management protocols, training curricula, and materials in the context of NMS 2013–2017 policy guidelines.

On January 22 and 23, *StopPalu* supported the NMCP to organize a workshop to validate the training manuals on malaria in pregnancy, case management protocols, and training curricula.

The workshop participants were representatives of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) project, CRS, Plan Guinée, *Médecins Sans Frontières* (Doctors Without Borders [MSF]) Suisse, the University Gamal Abdel Nasser of Conakry, the two national hospitals in Conakry, the IMNCI program, the Malaria Research Center of Maferinyah, the National Safe Motherhood Program, the *Système National de l'Information de la Santé* (National Health Information System [SNIS]), the NMCP, and *StopPalu*.

The objectives of the workshop were as follows:

1. Review the revised documents (training manual on malaria and pregnancy, case management protocols, and training curricula)
2. Ensure that these documents are in line with the National Malaria Control Policy and the new WHO recommendations
3. Make any appropriate changes and validate the documents

Workshop rollout

The key changes were the new protocol of case management for severe malaria, the number of doses of sulfadoxine pyrimithamine to give during pregnancy, and also the use of pre-referral treatment before referring severe cases. Participants also suggested that information about the dilution process for injectable artesunate for case management of severe malaria be added to the manuals. All the proposed changes were discussed, and the approved changes were included in the final documents. At the end of the two days, all the documents were approved and the NMCP authorized all partners to use these documents for future training.

Activity 2.2.2.3. Tailor training for facility-based staff and CHWs.

During this reporting period, *StopPalu* trained five CHWs per health center in the 14 prefectures covered by the project, trainers, and health providers (two per health facility) on malaria case management. Health providers from both public and private facilities benefitted from these trainings

Training of CHWs

For the reporting year, *StopPalu* began training CHWs in the region of Labé because it was the only region covered by the project that did not have trained CHWs trained on malaria community case management. During the Quarter 1, the project conducted initial training for 88 CHWs, including 33 women, from the 18 health centers of the Labé prefecture. The CHWs were trained on the use of RDTs, malaria case management (uncomplicated malaria), pre-referral treatment, and referral of severe cases. They also were trained on key messages to enable them to conduct home visits and promote healthy behaviors. The trainings were supervised by DPS and DRS staff to facilitate their engagement in the implementation and monitoring of the CHWs' performance. At the end of the trainings, all trained CHWs were provided with a kit with the following items:

- A package of RDTs (25 tests)
- A carryall to protect work tools
- A story board
- Management tools (notebook, home visit monitoring forms, and monthly reporting sheets)

Heads of health centers provided ACT for the treatment of simple cases confirmed by RDT.

During Quarter 2 of the reporting year, to increase the population's access to malaria prevention and treatment services, the project trained 24 trainers in the regions of Boké and Kindia and 14 in the region of Labé. Those trained were DPS doctors in charge of diseases and DPS staff in charge of training. After the training of trainers, the project selected those capable to train CHWs in each prefecture. In the region of Labé, the project used the national trainers to support the trainers at the DPS level to ensure training quality. This strategy was used because the CHWs in Labé were receiving their initial training, which required expert trainers. A total of 466 CHWs were trained by the project, among whom 274 CHWs received initial training and 192 received refresher training.

Similar to the training conducted during Quarter 1, the objectives of the training were to build the capacity of CHWs in malaria prevention, diagnosis, and treatment of simple malaria cases, and to enable them to identify the signs of danger and refer complicated malaria cases.

During the workshop, each participant practiced the use of RDT on his or her neighbor. To ensure the quality of the RDT training, a national RDT expert trainer delivered the training.

For the refresher trainings, the training focused on reinforcing CHW capacity and competencies on RDT use, case management, BCC, and data management tools.

For each prefecture, the project developed a directory of CHWs, including photos, full name, address, and the names of the villages they cover.

In Quarter 3, *StopPalu* conducted an initial training for 14 CHWs in the prefectures of Coyah and Dubréka to have five CHWs per health center.

The last trainings of CHWs in FY 2014 were conducted in Quarter 4 in the prefectures of Boffa, Conakry, Gaoual and Koundara, where the project conducted initial trainings for 112 CHWs.

Table 20: Number of CHWs trained on malaria case management

Prefecture	Number of new CHWs trained	Number of existing CHWs retrained	Total
Conakry	25	0	25
Coyah	7	19	26
Dinguiraye	15	25	40
Dubréka	7	37	44
Forécariah	33	17	50
Boffa	11	31	42
Boké	47	27	68
Fria	15	17	32
Gaoual	26	19	45
Koubia	28	0	28
Koundara	20	15	35
Labé	88	0	88
Lélouma	50	0	50
Mali	55	0	55
Tougué	46	0	46
TOTAL	473	207	680

*Training CHWs in Gaoual*

After the trainings, the CHWs began to conduct home visits in the villages, test fever cases, treat simple cases, and refer severe cases. However, in September 2014, due to the Ebola outbreak in four of the prefectures covered by the project, the NMCP recommended that the CHWs should no longer perform RDTs but rather treat all cases of fever with ACT and refer cases to the health center if there is no recovery. Because of the outbreak, the number of patients tested and treated by CHWs decreased during the last quarter of FY 2014 in some of the affected prefectures (Boffa, Coyah, and Dubréka). (See Tables 21 and 22.)

Table 21: Details of community case management conducted by CHWs in Quarter 3

Prefectures	RDTs performed	Number of positive RDTs	Number of negative RDTs	Number of people treated with ACT	% of positivity
Boffa	1,268	1,057	274	964	83.36
Boké	1,450	1,137	358	1,089	78.41
Coyah	1,412	877	515	877	62.11
Dubréka	1,950	1,329	661	1,329	68.15
Forécariah	1,286	826	460	826	64.23
Fria	830	590	225	544	71.08
Gaoual	712	462	176	462	64.89
Koundara	869	541	328	536	62.25.87
Total	7,059	4,625	2,148	4,574	65.51

Table 22: Details of community case management conducted by CHWs in Quarter 4

Prefectures	RDTs performed	Number of positive RDTs	Number of negative RDTs	Number of people treated with ACT	% of positivity
Boffa	799	616	183	616	77.09637
Boké	2,426	1934	492	1,933	79.719703
Coyah	813	560	253	560	68.880689
Dubréka	2,706	1,957	749	1,957	72.320769
Forécariah	1,707	1,126	581	1,126	65.963679
Fria	1,071	826	251	826	77.124183
Gaoual	1,656	1,202	423	1,202	72.584541
Koundara	1,276	926	244	888	72.570533
Total	12,454	9,147	3,176	9,108	73.446282

TOT for health facility staff on RDT use and case management

After the case management protocols and training curricula were validated, the project, in collaboration with the NMCP, conducted two training-of-trainers sessions. The first session took place in Boké during the week of March 24. The trainers from Conakry, Dubréka, and the five prefectures of Boké attended this session. The second workshop was held in Labé during the week of March 31. The trainers from Coyah, Forécariah, and the five prefectures of Labé participated in the training. The prefecture of Dinguiraye did not attend the training because of the Ebola outbreak in the prefecture. A total of 41 trainers were trained from the 13 prefectures and the five communes of Conakry.

Table 23: Number of health provider trainers trained, per prefecture

Prefecture	Number of trainers trained
Conakry	9
Coyah	2
Dinguiraye	0
Dubréka	1
Forécariah	2
Boffa	2
Boké	3
Fria	2
Gaoual	2
Koubia	2
Kindia	2
Koundara	2
Labé	6
Lélouma	2
Mali	2
Tougué	2
TOTAL	41

Training for facility-based staff:

After the training of the trainers conducted in Quarter 2, the project began training facility-based staff members (in health posts, health centers, and hospitals) from public and private facilities in PMI zones during Quarter 3, using the revised version of the training manual and protocols. The manual integrates RDT use, case management of simple and severe cases, IPT, BCC, and M&E. Each training lasted five days.

For these trainings, the project did not use cascade training because of the low capacity of the regional and prefectural trainers. In fact, the trainers at the regional and prefectural levels have no specific training background; they are often medical doctors and become trainers because of the position they occupy. They are the doctors in charge of disease or doctors in charge of planning and training at the regional or prefectural level. To ensure the quality of the trainings, the project combined a national trainer with a prefectural trainer for each workshop. Most of the time, national trainers deliver all the training sessions. Those participants that are not competent to conduct training still play a very critical role as supervisors.

The training participants were two people from each health center (the chief of health center and his/her alternate), four people from the hospital (maternity, emergency, pediatric, and general medicine), the chief of health post, and one representative from each of the private facilities that submitted their reports to the DPS.

One success of these trainings was the participation of the chiefs of health posts. During the trainings, the chiefs of health posts confirmed that this was the first time they ever received any type of training. For these trainings, the RDT sessions were delivered by the Malaria Diagnosis national trainers. Each participant practiced the use of RDT on his or her neighbor.

To ensure proper management of waste and in respect of the project's Environmental Management and Monitoring Plan (EMMP), the participants were also trained on biomedical waste management. These sessions were delivered by regional managers responsible for

hygiene. These managers had been trained by the project in collaboration with the national Division of Hygiene during this quarter.

During Quarter 3 of FY 2014, 690 health facility-based staff members were trained on new recommendations for malaria management and control, IPTp, as well as capacity building on BCC and waste management. At the end of the trainings, each facility received copies of the revised and validated protocols of malaria case management and prevention. A total of 776 copies of the protocols were distributed to 194 health facilities—278 in Boké, 86 in Kindia, and 410 in Labé.

In the last quarter of the reporting year, *StopPalu* organized seven training workshops in Conakry to train 156 staff members from public and private health facilities on case management. In the region of Labé, we organized four training sessions in the prefectures of Lélouma and Tougué to train 108 health providers on case management.

Table 24: Total number of facility-based staff trained on malaria case management

Prefecture	Number of public facility-based staff trained	Number of private facility staff trained	Total
Conakry	100	56	156
Coyah	32	3	35
Dinguiraye	50	0	50
Dubréka	45	9	54
Forécariah	73	2	75
Boffa	45	0	45
Boké	69	11	80
Fria	34	7	41
Gaoual	34	1	35
Koubia	45	0	45
Koundara	27	5	32
Labé	90	5	95
Lélouma	61	0	61
Mali	102	1	103
Tougué	47	0	47
Total	854	100	954

Activity 2.2.2.4. Strengthen the national supportive supervision system offered by district health team staff and health center heads.

In FY 2014, *StopPalu* supported the national supervision system at different levels. During Quarter 2 of the reporting period, *StopPalu* regional teams conducted joint supervision visits with the DRSs to monitor the quality of malaria control activities being implemented in each prefecture. These supervision visits were conducted in all four regions except for Conakry. The DCSs and DRS team in Conakry were all occupied with the household enumeration activities. In each prefecture, the DPS, the hospital, and three health centers with their CHWs were supervised. In total, 13 hospitals and 36 health centers were visited. These supervision sessions provided information on the performance of agents through on-the-job observation and verified the quality of data collected directly through primary tools.

For Quarter 3, *StopPalu* supported the DPS to conduct bimonthly supervision of malaria control activities in their prefectures. The supervision targeted hospitals, health centers,

health posts, and CHWs at the urban and rural levels. The supervisors used the national validated supervision tool.

During the last quarter of the reporting year, the project regional team of Labé conducted joint supervision visits with the DPS to monitor the quality of malaria control activities implemented in the prefecture. During the supervision in Labé, out of a total of 18 health centers in the prefecture of Labé, 12 were supervised plus the infirmary of the military camp. The supervisions also visited the households to verify the use of LLINs.

These supervision visits noted improvement in trained health provider performance, especially in the use of RDTs, respect for the case management protocol, and IPT use. However, it should be noted that other staff who have not received training continue to use poor practices. For this reason, we plan to train more health staff next year.

One common problem in all structures is the poor quality of waste management despite the training. Most of the facilities do not have incinerators, and they use pits that are poorly covered or not covered at all. Specific suggestions have been made to improve this situation, and the next supervision visits will verify their implementation. These supervisions have also shown the difference between the data reported on the malaria monthly forms and those in the health facilities registers. The supervision also identified that management tools (registry consultation, laboratory, the RUMER, etc.) are poorly filled out. For this reason, we are planning to revise these tools next year and orient agents on their use.

These supervision visits were very useful for capacity building of health providers. They helped correct the mistakes and misunderstandings found and also congratulate those who do good work. It is important to mention that these supervision visits allowed health authorities (DRS, DPS) to see first-hand what is happening in the health facilities. It is unfortunate that the authorities have no budget for supervision. They rely entirely on partners.

After each supervision, supervisors provided feedback at the health facility and at monthly monitoring meetings at the DPS with all the chiefs of health facilities. These feedback sessions with supporting photos allowed those who were supervised to recognize weaknesses and their potential impact on the quality of work and the health of the community.



A health facility staff member performing an RDT



A consultation book from a CHW in Labé



LLINs hung in houses

■ Specific Challenges and Measures Used/Planned to Overcome Them

Supervision is essential to ensure the quality of services, but its cost remains a challenge, especially when there are not many partners who support this activity. To minimize the challenges, *StopPalu* will continue to work with other actors in the field to co-finance supervision at DRS, DPS, and national levels.

3.3 Result 3: NMCP's Technical Capacity to Plan, Design, Manage, and Coordinate a Comprehensive Malaria Control Program Enhanced

3.3.1 Sub-result 3.1: MOH capacity to collect, manage, and use malaria health information for monitoring, evaluation, and surveillance improved

■ General Objective

To build MOH capacity to collect, manage, and use malaria health information for M&E and surveillance, we will work with MOH/NMCP counterparts to create clarity on roles and responsibilities for malaria data collection, quality control, and data use in decision making, including harmonization/rationalization of systems and processes for data collection and reporting.

During this period, the activities under this result focused on the following:

Activity 1. With MOH/NMCP and BSD³ counterparts, prepare a situation analysis and near-term action plan for streamlined coordination, collection, and analysis of malaria program indicator data.

From October 18 to 23, 2013, *StopPalu* organized a workshop in Dubréka with the NMCP M&E TWG and other partners (SIAPS, CRS, and Population Services International [PSI]) to finalize the NMCP Strategic Framework (2013–2017) and its M&E Plan, and to develop the budget for both documents. After the workshop, the project supported the NMCP to organize a two-day workshop to review these documents and ensure that they are in line with the latest recommendations with the support of a WHO-sponsored international consultant.

From November 18 to 19, 2013, the NMCP and all key partners involved in malaria control activities in Guinea; the eight DRS directors or their representatives; and representatives of other national health programs such as SNISS, PCG, IMNCI, and the reproductive health program met to review and validate these documents. This workshop was an opportunity to

³ Bureau of Strategy and Development (BSD)

share the documents with all the key actors, to ensure that the documents meet international standards and are aligned with the NSP.

On February 14, 2014, *StopPalu* supported the NMCP to validate and disseminate the NMCP Strategic Framework M&E Plan (2013–2017), developed with project support in FY 2013. This was done in the presence of the President of the Parliament, the Minister of Health, the Guinea PMI Advisor, and many other partners involved in malaria control in Guinea. Please see more details under Activity 3.2.2.5.

Activity 3.1.4.1. Support facility-based data collection.

In Quarter 1 of the reporting year, to improve data collection at the health facility level, *StopPalu* trained health provider trainers on the national malaria monthly reporting system consistent with updated M&E and SNIS plans and developed a routine data quality assurance system implemented through supportive supervision. *StopPalu* used the validated NMCP M&E training manual. These trainers trained health providers on the reporting system and the importance of collecting correct data during the following quarter. In total, 41 trainers from the 13 prefectures (except Dinguiraye) and 4 communes of Conakry (Kaloum excepted) were trained on the reporting system.

During Quarter 3, the project used the training sessions for health facility staff on case management as an opportunity to retrain them on the malaria monthly reporting form. A total of 690 health staff members were trained.

The objectives of the refresher training were the following:

1. Ensure that the participants are familiar with the reporting form and are able to fill out the form properly.
2. Clarify roles and responsibilities of actors in collecting, reporting, and analyzing malaria data.
3. Discuss the process of filling out the forms and the importance of the monthly monitoring meeting at the health center.

This training was appreciated by the participants because it helped answer many questions they had. The project and the NMCP also understood the reasons for the poor quality data that were submitted. After the trainings, the project began to support the monthly meetings at the health centers and DPS levels as recommended by the trained health staff.

During Quarter 4, 156 health facility staff members were trained in Conakry and 108 in the prefectures of Lélouma and Tougué. In total during FY 2014, a total of 995 chiefs of health centers and alternates were trained on the malaria monthly reporting form.

Support monthly monitoring meetings of the health centers

To improve the quality of malaria data collected at the health centers, during the reporting period the project, in collaboration with its NGO partners, organized monthly meetings to compile and analyze data at each health center. During these meetings, the health facility registers were used, as well as reports from CHWs and health posts, to fill out the malaria monthly report form. The reports were analyzed, and recommendations were made for the next month.

In total for this quarter, the project supported 258 monthly monitoring meetings in 86 health centers of the regions of Boké, Kindia, and Conakry. As a result, we are seeing some improvements both in the completeness and timeliness of reports transmitted. Among the 171 health facilities (health centers and hospitals) that submit their monthly report to the

DPS/DCS in PMI regions, 107 (63%) submitted complete reports on time during the reporting quarter. However the biggest challenge remains the big difference between the data reported in the Malaria monthly forms and the one in the register.

In the regions, after training health staff on the malaria monthly form during Quarter 3, we have seen progressive improvement in the quality of these reports, especially regarding consistency with information in the registers. The training in Conakry occurred in July and August 2014. We hope to see improvement during Quarter 1 of 2015.

Activity 3.1.5.1. Increase use of data collected routinely by supervisors.

In Quarter 3 of the reporting period, to increase the quality of data analysis at the prefectural level and reduce errors, the project started to support the DPS to organize monthly meetings with the participation of all chiefs of health centers to review, discuss, correct, and analyze data. The NMCP and representatives from SIAPS attended some of these meetings in the prefectures. During the reporting period, the project supported 114 meetings (one per month for the 14 DPSs and the 5 DCSs). These meetings are very helpful in improving the quality of data. None of the chiefs of health centers wants to be blamed for the same errors more than once. Therefore they are making efforts to improve the reporting. These meetings also help participants understand the status of the disease as well as the prevention and treatment activities in each facility and prefecture, including at the community level. They give information about the commodities and can help reduce the risk of stock-outs. We are seeing some improvement in the regions after the trainings



Participants at the monthly monitoring meeting in Gaoual; the DPS presenting the report

However, to increase the impact of these meetings, it is important that the following be recognized:

- The DPS and DCS should have the resources to organize these meetings with no support from a project.
- The malaria monthly reporting forms should be available in all the facilities.
- An M&E guide that defines the roles and responsibilities of each actor in data collection, transmission, and analysis needs to be developed.

For FY 2015, in order to improve the quality of data management, *StopPalu* plans to finalize the M&E guide and orient health facility staff on the new guide, as well as increase supervision to verify the quality of data collected.

■ Specific Challenges and Measures Used/Planned to Overcome Them

The low ability of agents to correctly use the registers and the difference between the data reported on the malaria monthly forms and those in the registers remain major challenges for

improving data quality. To minimize these challenges, *StopPalu* proposes to support the SNIS and the health programs to review the health facility registers and orient agents on how fill out these tools. The project will also increase supervision to verify compliance of data collected

Sub-result 3.2: The NMCP coordination capacity strengthened

■ General Objective

To strengthen NMCP coordination capacity, we will build on the progress made to date training and mentoring NMCP counterparts to enact organizational strategies essential to fulfilling their leadership role—in coordination with public and private partners; other national programs; and institutional stakeholders, donors, and the private sector.

During this period, the activities under this result focused on support to the NMCP. These activities are briefly described below.

■ Specific Activities and Results

Activity 3.2.1.1. Support organizational self-diagnosis of the NMCP and, based on findings, develop a plan to strengthen NMCP's malaria prevention and control knowledge and skills and coordination function.

During Quarter 1 of this reporting year, *StopPalu* organized a self-diagnosis of the NMCP. The workshop was attended by 5 regional health directors (Faranah, Kindia, Labé, Boké, and Conakry), 5 commune-level health directors from Conakry, and 12 NMCP staff.

Activities conducted during the three-day workshop examined information related to (1) understanding the NMCP NMS 2013–2017 and the different actors involved, (2) different actors and the roles assigned to each as well as collaborative linkages and interdependence between actors, (3) the NMCP's structure and operation, (4) systems and tools used for the management of NMCP resources (financial, material, and human), (5) the development and management of NMCP's external environment, (6) the NMCP's communication system, and (7) the organization and management of implementation of NMCP activities.

The self-assessment was conducted through a participatory process, and facilitation highlighted skills demonstrated during self-assessment.

In terms of methodology, moderation of the workshop relied on plenary presentations, individual and group exercises, small-group sharing and reflection, analysis of results or information presented, the formulation of possible solutions to capacity-building needs, and determining how to measure successful consolidation throughout NMCP practices.

The results of the assessment were presented to the partners and MOH officials on June 30 during the Roll Back Malaria (RBM) quarterly meeting. During the meeting, *StopPalu* presented the synthesis of two NMCP assessments conducted by the Leadership, Management, and Governance (LMG) and *StopPalu* projects. In fact, after sharing the two reports, both projects realized that although the tools and methodology of diagnoses were different, the findings and recommendations were very similar and complementary. On NMCP recommendations, the two projects decided to make a synthesis of the two assessments and develop a single capacity-building plan that will be shared with the MOH and partners.

These assessments helped identify real needs and problems of the NMCP as well as proposed solutions. They showed the strengths and the areas that need improvement. The strengths were the availability and willingness of the NMCP's management team for change, the

availability of some management tools, and the willingness of staff to support various partner activities. TWGs exist. The NMCP coordination team organizes weekly staff meetings to discuss activities implemented and planned.

Regarding the weaknesses, the first main one identified concerned human resources: lack of qualified human resources, no system of operational management of human and material resources, and tasks and responsibilities of personnel not clearly written or available. Personnel policies, even if they are written, approved, and available at MOH, are not commonly known by the NMCP staff. There is no transparent system of recruitment; the staff is recruited by the MOH with no consideration of the NMCP's needs. This explains the high number of staff at the NMCP, but because their profiles do not match the needs of the program, these people cannot support NMCP to meet its mission.

The second identified weakness is the lack of financial resources from the MOH to the NMCP. The program needs a budget to enable it to perform its coordination role. The NMCP does not have an internal audit system, and the financial report is not reviewed by the MOH. Their financial system does not satisfy the NMCP coordinators or the donors.

The third weakness is the deficiency in communication. The NMCP has no communication specialist. The program has no system of communicating with partners or beneficiaries. They do not have a website or periodic newsletter to inform the population on malaria control activities implemented in the country. There is no annual report of activities.

Some other problems found are the weakness of partnerships with the private sector, and that the NMCP work plan does not include activities of all its partners.

Based on these findings, *StopPalu* worked with the NMCP to develop a capacity-building plan that addresses the different weaknesses. During the last quarter of the reporting year, upon the recommendations of the RBM committee, the plan was revised and presented for short-, mid- and long-term activities with clearly identified responsible parties for each activity of the plan. However, we did not have a chance to present the plan to the MOH management team because of the Ebola outbreak. We expect to be able to do so during FY 2015 when the MOH team will be available.

Activity 3.2.1.3. Provide NMCP with equipment and materials.

During the reporting period, *StopPalu* provided the NMCP office with Internet connection and equipped their meeting room with an air conditioner and chairs. These materials will enable the NMCP to hold important meetings with staff, partners, and donors.

Activity 3.2.2.1. Support the NCMP to conduct TWG and partner meetings.

During the reporting year, *StopPalu* worked with the LMG project and other partners to support the NMCP establish some new TWGs as vector control, BCC TWGs, but also reinforce the existing ones. During the last quarter of the year, all the scopes of work were revised, and work plans for each TWG were developed and validated. For the last quarter, all the TWGs have conducted their monthly meetings and are monitoring the implementation of their work plans.

Activity 3.2.2.2. Strengthen the national RBM committee that meets quarterly.

During FY 2014, *StopPalu* continued to support the NMCP in organizing the quarterly meetings of the RBM committee to review and validate major malaria program activities and resources (LLIN mass distribution campaign, world Malaria Day, discussion of commodities, surveys, NCMP work plan, etc.); harmonize activities; facilitate the review, dissemination,

use, and application of national policies, guidelines, and standards; and identify and resolve technical and funding gaps for the implementation of the NMS. For the reporting Year 4, meetings were held, and the meeting minutes were shared with the participants.

Activity 3.2.2.4. Support NMCP supervision responsibilities.

During the month of August 2014, *StopPalu* supported the NCMP to organize a two-day workshop to revise the national supervision guide according to the malaria control policy. Most of the partners involved in malaria control in Guinea attended the workshop. The supervision guide integrates all aspects of malaria control activities, including prevention, diagnosis, treatment, commodities, communication, and reporting, and involves all levels of the health system, from the DRS to the community level. At the end of the two days, the NMCP's M&E team was in charge of finalizing the guide and integrating all approved comments. The final document was presented and validated during the first week of October. Depending on the evolution of the Ebola outbreak, the project will support the NMCP to conduct national supervision during Quarter 1 of FY 2015.

Activity 3.2.2.5. Edit and disseminate national documents on malaria control.

In February 2014, *StopPalu* supported the NMCP's editing and dissemination of the National Malaria Control Policy, the NSP (2013–2017), and the M&E Plan to government official, partners, MOH directorates (national, regional, prefectural), private and public health facilities (hospitals, health centers), other national programs, and other stakeholders. This was done through a one-day workshop, which led to the signature of the *Aide-Memoire* (the summary of the key findings of the review of the program and the recommendations) and the dissemination of the NSP. The President of the Guinea Parliament chaired the workshop.

The objectives of the adoption workshop were as follows:

- To reinforce the utilization of the NMCP's national policies, guidelines, and plans.
- Obtain commitment from Government and partners to finance the NSP 2013–2017.
- Adopt and disseminate normative documents (National Malaria Control Policy, NSP, and the M&E Plan).
- Share the next steps for effective implementation of the NSP.

The end of the ceremony was marked by the signing of the memorandum by the President of the Parliament, the Minister of Health, the Chairman of the Global Fund Country Coordination Mechanism, and the UNICEF representative. This day was a great day for the NMCP and its partners—this ceremony was the finalization of a process that started in March 2012.



The President of Parliament and Minister of Health during the adoption of NSP and signing of the Aide-Memoire

After the workshop, the project distributed one copy of each document to the 14 DPSs, 5 DCSs, and 4 DRSs covered by the project. Copies were also sent to all partners involved in malaria control in Guinea that were present in Conakry.

Activity 3.2.3.1. Develop/update M&E manual, and train and orient NMCP M&E staff.

During Quarter 3 of the reporting period, the project and the NMCP recruited a national consultant to develop an M&E manual with clear roles and responsibilities for M&E data collection, analysis, and use. We expect to finalize and validate the manual during Quarter 1 of FY 2015. *StopPalu* will then train and orient MOH/NMCP, *StopPalu* staff, and NGO partners on roles and responsibilities for collecting, reporting, and analyzing malaria data as part of the SNIS, and as a function of good malaria prevention and control programming. We will encourage the use of free and open-source software where it meets essential needs and can be locally sustained.

Activity 3.2.4.1. Rehabilitate and reactivate sentinel sites for capture of mosquitoes.

For the reporting period, *StopPalu* supported the NMCP's entomological unit to conduct five site visits in four sentinel sites (Boké, Kankan, Kissidougou, and Labé) to capture mosquitoes to facilitate national entomological monitoring and surveillance. *StopPalu* helped the NMCP procure some basic field equipment for routine entomology monitoring. The project also paid for per diems and hotels for the NMCP staff and local collectors.

It is important to mention that the NMCP team did not complete all planned entomological monitoring visits for the year. The Kissidougou site was the only site that was visited twice during the reporting year. This was due to reasons such as the Ebola epidemic, the development of the Global Funds proposal, and the national census of all public employees. Because the project did not have the agenda for the annual monitoring visits, we were not able to advocate with the NMCP leadership team for them to ensure the entomological team followed the agenda.

Activity 3.2.4.2. Support the NCMP to establish an insectary.

In February 2014, a joint team (NMCP, the CDC, and *StopPalu*) visited the University of Conakry. The team met with the Director of the university and his colleagues to discuss future collaboration with the NMCP to establish a vector control and entomology laboratory facility and associated insectary on the main campuses of the university. The key recommendation of the meeting was to develop a memorandum of understanding (MOU) between the NMCP and the university. The purpose of this MOU would be to outline, in general terms, the roles and responsibilities of partners (the NMCP and the university) in establishing a vector control and entomology laboratory and associated insectary, as well as to act as a subsequent mechanism for assuring effective and ongoing management/maintenance of the facility to support NMCP's entomological monitoring and surveillance activities for malaria prevention and control in Guinea. *StopPalu* proposed to develop a draft MOU to be finalized by both parties. After the meeting, the team inspected and identified a suitable location on the second floor of the biology department building.

In March 2014, *StopPalu* sent the draft MOU to the NMCP for amendment before sending it to the university for feedback. However, the MOU between the NMCP and the University of Conakry for the establishment of the insectary was only signed in June after several meetings with the university team. As per USAID regulations, the project developed an Initial Environmental Examination (IEE) amendment for the establishment of the insectary and entomology laboratory. The purpose of the IEE amendment is to review the activities linked

to the establishment of the proposed insectary/entomology laboratory and provide threshold determinations of environmental impact and the conditions for effective mitigation in order to ensure that the proposed activities are environmentally sound. The amendment was sent to USAID for review and approval during the month of July.

In August during the visit of the CDC expert, a joint team (NMCP, PMI/CDC, *StopPalu*) visited the selected site for the insectary to agree on the renovation works that need to be carried out to establish the insectary. After the visit, *StopPalu* launched a tender to collect technical and financial bids for the performance of work. A selection committee composed of *StopPalu* and NMCP analyzed the bids and selected a contractor. We await the approval of the IEE to start renovation work.

■ Challenges and Specific Measures Used/Planned to Overcome Them

The Ebola outbreak has further complicated the availability of MOH officials. Implementation of some recommendations from the NMCP assessments require their involvement and decision making. To ensure the implementation of these recommendations, *StopPalu* will continue to monitor the evolution of the Ebola epidemic in order to work with officials from the Ministry as soon as possible.

3.4 Project Management

During this reporting period, project management activities focused on the submission of project deliverables, human resources (short-term technical assistance [STTA]), procurement, and partnerships. These activities are briefly described below.

Activity 4.1. Project deliverables

During Quarter 1 of the reporting period, the project, at the request of the Agreement Officer's Representative (AOR) and USAID, submitted the revised program description and the realigned budget in line with the Malaria Operational Plan (MOP). The project's FY 2014 Work Plan was also revised and resubmitted.

The other project deliverables such as the Branding and Marking Plan, the IEE, and the Performance Management Plan (PMP) were approved.

Activity 4.2. Staffing and human resources

Activity 4.2.1. Staff recruitment

During this reporting period, the project finalized the recruitment of two M&E specialists for the regional offices located in Forécariah and Labé and oriented them on the project.

The project signed five grants with the national NGO partners INAASPO, CAM, and CJMAD to support malaria control activities in the regions of Boké, Conakry, and Kindia. The project also received the approval for the recruitment of two local NGOs to support the project activities in the region of Labé. These NGOs will begin activities in FY 2015.

Activity 4.2.2. STTA

During Quarter 2 of the reporting year, the project received two STTA visits from RTI headquarters. The first visit focused on support to the project for human resources management, and the second supported the project to prepare for execution of the entomology work plan during 2014, with targets and milestones in line with available project funding allocation.

In Quarter 2, the project received two other STTA visits from RTI headquarters. The first visit focused on support to the project for grant management, and the second supported the project to develop the FY 2015 work plan.

These STTA supported the team in implementing its activities and on some project management issues, with the objective of strengthening project implementation and staff and partner capacity.

3.5 Procurement

During Quarter 2 of the reporting year, the project received the six vehicles that had been purchased.

3.6 Partnership

Consistent with the project's "With Many" approach, RTI submitted a technical and financial proposal in October 2013 at the request of UNICEF. The objective of the proposal was to store and distribute 280,900 LLINs, procured by UNICEF with funding from the Government of Japan, in the Lélouma and Mali prefectures. The agreement was signed in October, and RTI distributed these nets during the mass LLIN distribution campaign. This was considered as cost share for the project.

During Quarter 2 of the reporting period, *StopPalu* implemented a collaborative project with Alcoa. Under this project, *StopPalu* organized 7 mobile clinics targeting 12 villages covered by Alcoa activities. Through these activities, 1,304 persons were reached by malaria general information (causes, prevention measures, and treatment methods). Under this collaborative project, 343 persons with fever were tested using RDTs, and 42 persons having positive results received ACT. These activities were conducted by project-trained CHWs, field agents of the project's NGO partners, and project staff under the supervision of the Boké DPS team. This activity also was considered as cost share for the project.

3.7 M&E

Activities described in the preceding sections have contributed toward achievement of project performance indicators. Achieved results described by indicators are attached to this document (see *Annex A*).

Indicator data was collected by *StopPalu* M&E staff, technical staff, and partner NGO staff responsible for implementing project activities.

During the reporting period, the project activities focused on the mass LLIN distribution campaign, training of CHWs and health facility-based staff, and BCC; therefore, a significant number of project performance indicators linked to these activities were collected. To minimize errors during collection, project technical staff and national partner NGO field agents were trained on how to collect this data, and they received the appropriate tools. In accordance with the M&E plan approved by USAID, collection was conducted in all 14 prefectures and Conakry.

3.8 Other Activities

Visit of Tom Hall, PMI/Washington

On December 3, 2013, *StopPalu* met with Tom Hall, PMI/Washington Advisor, at the project office. During the meeting, the project presented the preliminary results of the net distribution campaign, discussed challenges, and made some recommendations.

The project also organized a field visit for Mr. Hall to Dubréka. The team visited the urban health center of Dubréka, focusing on three units: the care unit, the ANC unit, and the pharmacy. During the visit, Mr. Hall asked several questions on malaria prevention, diagnosis, and treatment services delivered at the center. He also asked questions about reporting, supervision, and data analysis.

After the health facility visit, the mayor and his staff received the team and voiced their appreciation of PMI support through *StopPalu*, indicating satisfaction with the project team's performance. The mayor noted that he was impressed that the LLIN campaign this time reached some areas that were never covered before due to extremely difficult access.

The team also visited the rural commune of Tersè, where the mayor mobilized his community to meet with us and share their opinions about the LLIN campaign and project activities. All persons present indicated that they were happy with the campaign and their CHWs. They confirmed that all the households had been enumerated and received an appropriate number of nets based on the number of sleeping spaces in the household. At the end of the meeting, Mr. Hall asked if all those present had hung their nets and they answered in the affirmative. He asked if he could choose one person and visit their home. They agreed, so he randomly selected one lady with a baby and we visited her house. We found that this household received three nets, and the nets were all hung above the beds.

We also visited the commune's CHW. Mr. Hall asked several questions about the CHW's activities and checked his book and other tools. The mayor of Tersè advocated for a second CHW to help cover all the villages. He also requested that we visit a health post that the community built (but which is not functional due to the lack of a health provider).

On our return to Conakry, we met some of our post-distribution hanging and awareness-building teams working in roadside communities and we took a picture with them.

Supporting the NCMP in the development of the Global Fund proposal

During the reporting year, the project supported the NMCP in developing their Global Fund proposal. The project's senior staff were members of various committees (program, diagnosis and treatment, BCC, and M&E) for this effort. During the week of March 24, the project participated in a retreat in Kindia for the proposal team.



The proposal team during the retreat

3.8.1 Distribution of three microscopes and laboratory supplies to three hospitals in Coyah, Boffa, and Labé

Based on the results of the diagnosis capacity assessment, the project and the NMCP found that among the 19 facilities visited, 3 had the competencies to use microscopes and were complying with the diagnosis process, but they did not have the necessary equipment. After

sharing the results of the assessment, the Diagnosis and Case Management TWG recommended that each of these three hospitals receive one microscope and lab supplies to enable them to perform quality malaria diagnosis. During the month of March, *StopPalu* distributed these commodities.



Microscopes provided to health facilities in Labé

3.8.2 Celebrate World Malaria Day

As part of the celebration of World Malaria Day, April 25, 2014, *StopPalu* organized community mobilization activities in all the project regions except Conakry. In Conakry, the MOH decided that due to the Ebola epidemic, there would be no official community mobilization activity. To celebrate the day, the Minister of Health read a speech that was broadcast on the radio and television. In his speech, he advocated for more donors to contribute in the fight against malaria, especially the private sector.



Officials attending the ceremony in Forécariah



The Malaria Day ceremony in Forécariah

3.8.3 Support the NMCP to organize the feedback meeting for the MOP 2015

On May 2, the project supported the NMCP to organize the MOP 2015 information sharing meeting. The meeting was attended by the Minister of Health and many senior staff of the MOH, the MOP team, the Health team leader of USAID/Guinea, and representatives of all partners implementing malaria activities in Guinea. During the meeting, the NMCP coordinator presented the main activities that will be funded by PMI in 2015. The MOP included all aspects of malaria control activities—prevention, diagnosis, case management, M&E, BCC, and support of the NMCP, with an important procurement component. At the end of the meeting, the Minister of Health thanked the American Government and PMI for all their support to improve the health of the Guinea population.



MOP 2015 information sharing meeting



MOP 2015 information sharing meeting

Annex A. StopPalu Performance Indicator Tracking Table (FY 2014)

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 <i>Actual</i>	FY14-Q2 <i>Actual</i>	FY14-Q3 <i>Actual</i>	FY14-Q4 <i>Actual</i>	FY14 <i>Annual Target</i>	Notes
OVERALL PMI SUPPORT							
Indicator 1: All-cause mortality rate among children under five years old (U5)	122 deaths / 1,000 live births (Source: DHS 2012)	N/A			NA		This indicator will be collected through DHS 2016.
Result 1: IMPROVED MALARIA PREVENTION IN SUPPORT OF THE NMS							
Result 1.1: Supply and use of LLINs increased							
Indicator 1.1.a: % households with at least one LLIN (PMI Required Indicator)	47.4 EDSG-MICS IV-2012	N/A			NA	75%	This indicator will be collected through the MIS 2015.
Indicator 1.1.b: % pregnant women who slept under an LLIN the previous night (PMI Required Indicator)	28.3% EDSG-MICS IV-2012	N/A			NA	70%	This indicator will be collected through the MIS 2015.
Indicator 1.1.c: % children U5 who slept under an LLIN the previous night (PMI Required Indicator)	26.2% EDSG-MICS IV-2012	N/A			NA	80%	This indicator will be collected through MIS 2015.
Indicator 1.1.d: Number of LLINs purchased by USG funds that were distributed through campaign in PMI regions	0	1,039,434	0	268,288	0	1,353,150	
Indicator 1.1.e: Number of LLINs purchased by USG funds that were distributed through routine distribution in PMI regions	0	0	0		0	180,000	The routine distribution will begin in December 2014.
Indicator 1.1.f: Number of LLINs purchased by other donors that were distributed with USG funds through campaign in PMI regions	0	741,250	0	210,537	0	1,282,000	The project also distributed in 2 PMI prefectures 280,900 LLINs procured with the Japanese Government funds
Indicator 1.1.g: Number of person trained in LLINs distribution,	0	10,940	1,576 (317 women)	1,353 (303)	0	10,027	

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 Actual	FY14-Q2 Actual	FY14-Q3 Actual	FY14-Q4 Actual	FY14 Annual Target	Notes
microplaning, enumeration, distribution, hang-up and or promotion				women)			
Result 1.2: Intermittent preventive treatment in pregnancy(IPTp) uptake increased							
Indicator 1.2.a: % women who received two or more doses of sulphadoxine-pyrimethamine (SP) during their last pregnancy within the last two years in intervention areas (PMI Required Indicator)	17.8% (EDSG- MICS IV-2012)	N/A	NA	NA	NA	60%	This indicator will be collected through MIS 2015.
Indicator 1.2.b: # health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds <i>Data are disaggregated by gender and paid public health workers/community volunteer health agents.</i> (USAID Guinea Mission Indicator 3.1.3.4-1)	107 (Faisons Ensemble	0	41 public paid health workers	690(154 women): 646 public health workers (148 women) 44 private health facility workers (6 women);	321(142 women 272 public health workers (129 women), 49 private health facility workers (13 women);	661	During the last quarter of FY 2014, the project trained 272 public paid health workers (129 women), 49 private health workers (13 women) and 14 CHWs on IPTp. 156 workers (60 women) in Conakry, 108 workers (35 women) in Labé and 57 ANC staff (47 women) in Conakry.
RESULT 2: DIAGNOSTIC TESTING AND MALARIA TREATMENT CAPACITY IMPROVED							
Result 2.1: Diagnostic capacity and use of diagnostic testing improved							
Indicator 2.1.a: % health centers with the ability to perform diagnostic testing for malaria (microscopy and/or rapid diagnostic testing) (PMI Required Indicator) <i>Numerator: health centers with ability to perform diagnostic testing for malaria; Denominator: health centers in intervention area</i>	40%	N/A	0	72,84% (110/151)	100 % (151/151)	80%	Among the 151 health centers covered by the project, 41 were trained on malaria diagnosis during the reporting quarter. This makes a total of 151 trained health facility staffs.
Indicator 2.1.b: % community health workers capable of using rapid diagnostic tests (RDTs) at household level (PMI Required Indicator)	45% (308 trained CHWs of 680)	12.9% (88/680)	68.5% (466/680)	83.5% (568/680)	100%(68 0/680)	90%	During the last quarter of FY 2014, the project trained 112 new CHWs (16 women) on the use of RDTs. This makes a total

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 Actual	FY14-Q2 Actual	FY14-Q3 Actual	FY14-Q4 Actual	FY14 Annual Target	Notes
<i>Numerator: CHWs capable of using RDTs at household level, Denominator: CHWs in intervention area</i>							of 568 trained CHWs.
Indicator 2.1.c: % diagnostic tests (microscopy and/or RDTs) interpreted correctly (positive–negative) (PMI Required Indicator)	10% microscope tests interpreted correctly according to Improving Malaria Diagnosis Project (IMaD)	0		96%	98%	50%	During the last quarter of the reporting year, the project conducted a joint supervision with Malaria Care in 6 regional and national hospitals. 60 slides were inspected. The results of these tests showed that among the 60, 59 were interpreted correctly.
Indicator 2.1.d: # health workers trained in malaria diagnostics with USG funds <i>Data are disaggregated by gender and paid public health workers/community volunteer health agents. (USAID/Guinea Indicator 3.1.3.1-5)</i>	62 individuals trained on microscopy and RDTs by IMaD (nationwide)	88 (33 women)	507 (53 women)	719 (159 women) among whom 646 (148 women) public paid health workers, 44 (6 women) private facility workers; 14 (2 women) CHW and 13 (3 women) paid lab technicians and 2 private lab technician.	507 (188 women) among whom 272 (129 women) public paid health workers, 49 (13 women) private health workers; 112 (16 women) and 66 (28) public lab techs and 8 (2 women) private lab techs	Microscopy 60, TDR: 1596 *	During this quarter, the project trained 272 (129 women) public paid workers, 49 (13 women) private health workers, 112 (16 women) CHWs and 66 (28 women) public paid lab technicians and 8 (2 women) private lab technicians.

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 <i>Actual</i>	FY14-Q2 <i>Actual</i>	FY14-Q3 <i>Actual</i>	FY14-Q4 <i>Actual</i>	FY14 <i>Annual Target</i>	Notes
Result 2.2: Case management of uncomplicated and severe malaria improved							
Indicator 2.2.a: % patients (all ages) who tested positive (via microscopy or RDT) and who received an effective anti-malarial (PMI Required Indicator)	According to NMCP baseline is low but official data unavailable	0	98% (77,999/ 79,627)	97,45% (87,556/ 89,851)	97,20% (141188/ 145254)	40%	During the reporting period, in the 14 prefectures and 5 communes of Conakry (project coverage area), 145,254 people tested positive for malaria; among those, 141,188 received an effective antimalarial. Please note that these data are collected by health facilities.
Indicator 2.2.b: % patients with suspected malaria referred for a diagnostic test (microscopy or RDT) (PMI Required Indicator)	N/A	0	91% (10,513/ 115,295)	98,22% (134,373/ 136,808)	98,88% (202643/ 204946)	60%	During the reporting period, in the 14 prefectures and 5 communes of Conakry (project coverage area), there were 204,946 suspected malaria cases; among those, 202,643 received malaria tests. Please note that these data are collected by health facilities.
Indicator 2.2.c: % patients with a negative diagnostic test who received treatment for malaria (PMI Required Indicator)	N/A	0	12% (3,070/ 25,507)	1,55% (689/ 44,522)	11,84% (6795/57 389)	<15%	During the reporting period, in the 14 prefectures and 5 communes of Conakry (project coverage area), patients 57,389 had a negative diagnosis test; among those, 6,795 received treatment for malaria. Please note that these data are collected by health facilities.

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 Actual	FY14-Q2 Actual	FY14-Q3 Actual	FY14-Q4 Actual	FY14 Annual Target	Notes
Indicator 2.2.d: % health workers nationwide with malaria-related responsibilities that received at least one supervision every three months (PMI Required Indicator) <i>Numerator: health workers in intervention area receiving at least one supervision visit every three months, Denominator: health workers in intervention area</i>	Estimate of 30% provided by NMCP	N/A	29.6% (308/1,038)	14,74% 153/1038	17% (176/1038)	65%	During the reporting period, 176 health agents were supervised in PMI area. The project supported the DPS of Fria, Gaoual and Labé to conduct supervision visit, 118 health workers were supervised. The project regional team supervised 58 health workers in the prefectures of Boké, Coyah and Dubreka.
Indicator 2.2.e: % of children under 5 with fever in the last 2 weeks who received treatment with ACTs within 24 hours of onset of fever (PMI Required Indicator)	1.4% (EDSG-MICS IV-2012)	N/A			NA	70%	This indicator will be collected through the MIS 2015.
Indicator 2.2.f: # health workers trained in case management with ACTs with USG funds (USAID Guinea Mission Indicator 3.1.3.1-1) <i>Data are disaggregated by gender and paid public health workers/community volunteer agents.</i>	455 (<i>Faisons Ensemble</i>)	88 (33 women)	507 (53 women) 41 paid public health workers and 466 CHWs	704 (156 women) Among whom 646 (148 women) public paid health workers, 44 (6 women) private facility workers; 14 (2 women) CHW and 13 (3 women)	376 (111 women) 219 (86 women) Public paid health workers, 45 (9 women) private facility workers , 112 (16 women) CHWs	1536 680 CHWs	During this quarter, the project trained 376 paid public health workers, 45 private health workers and 112 CHWs in case management with ACTs
RESULT 3: NMCP's TECHNICAL CAPACITY TO PLAN, DESIGN, MANAGE, AND COORDINATE A COMPREHENSIVE MALARIA CONTROL PROGRAM ENHANCED							
Result 3.1: MOH capacity to collect, manage, and use malaria health information for M&E and surveillance improved							
Indicator 3.1.a: Comprehensive malaria M&E plan developed and	A national M&E plan for malaria	1				A national M&E plan	

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 Actual	FY14-Q2 Actual	FY14-Q3 Actual	FY14-Q4 Actual	FY14 Annual Target	Notes
implemented as an integral part of the new National Malaria Strategic Plan (PMI Required Indicator)	is not in place					for malaria is available.	
Indicator 3.1.b: Number of NMCP/SNISS staff trained in data quality, management and data analysis with at least 75% score during post-test.		0	0	0	0	15	The project will finalize the ME manual during the first quarter of 2015 and begin the training of staff.
Indicator 3.1.c: Number of health Information officers at regional and prefectural levels trained in data quality, management and data analysis with at least 75% score during post-test.		0	0	0	0	23	Please see the comment above
Indicator 3.1.d % of Health facilities submitting timely and complete reports according to national guidelines	30% (Source: NMCP records in 2012)	N/A	82%	64,58%	63%	45%	Among the 171 health facilities (health centers and hospitals) that submit their monthly report to the DPS/DCS, 63 % submitted complete reports on time during the reporting quarter.
Indicator 3.1.e: number of sites where entomological monitoring and insecticide resistance testing conducted	N/A	1	1	2	1	6	During the past quarter, the project supported the NMCP to conduct entomological monitoring and insecticide resistance testing in the prefecture of Kissidougou.

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 <i>Actual</i>	FY14-Q2 <i>Actual</i>	FY14-Q3 <i>Actual</i>	FY14-Q4 <i>Actual</i>	FY14 <i>Annual Target</i>	Notes
RESULT 3.2: The NMCP coordination capacity strengthened							
Indicator 3.2.a: Assessment/organizational audit of NMCP conducted (PMI Required Indicator)	N/A	1	NA	NA		1	
Indicator 3.2.b: Recommendations of assessment/organizational audit of NMCP implemented (PMI Required Indicator)	N/A	0	1	2	1	5	During the reporting quarter, the project supported the NMCP deputy coordinator to participate in a workshop to improve the partnership with the private sector.
Indicator 3.2.c: # quarterly coordination meetings under NMCP's leadership held with meeting minutes distributed (PMI Required Indicator)	Not applicable	1	1	1	1	4	On October 3, the project supported the NMCP to organize the quarterly meeting of the national RBM committee.
GOVERNANCE INDICATORS							
Indicator G.a: % of citizens surveyed in targeted project areas who report a favorable opinion of the performance of their local health center in the area of malaria prevention and control in the past year <i>Data are disaggregated by gender, geographic locale, and age.</i>	73% was reached under <i>Faison Ensemble</i> for health generally, but information for malaria specifically is unavailable	N/A			NA	80%	This indicator was collected by the KAP survey conducted by the project during the past quarter. We expect to receive the report by December 2014.
Indicator G.b: # health centers that publicly post the price of their services and products	N/A	N/A	35	25	38	70	During the quarter, 38 new health facilities posted the price of their services and products (27 in Boké and 11 in Kindia).

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 Actual	FY14-Q2 Actual	FY14-Q3 Actual	FY14-Q4 Actual	FY14 Annual Target	Notes
Indicator G.c: # citizen-led public meetings or other forums for citizens to engage local or regional government officials on malaria-related policies, performance, or services in the last reporting period <i>Data are not disaggregated.</i>	N/A	0	0	4	22	10	During the reporting quarter, 22 community meetings were organized, 13 in Boké, 8 in Conakry, and 1 in Forécariah.
Indicator G.d: # members of local NGOs that have received training in monitoring the use of public services in malaria-related services and advocacy with project support in the last reporting period. <i>Data are disaggregated by gender.</i>	34 individuals trained through <i>Faisons Ensemble</i>	0	0	69	56	125	During the reporting quarter, the project trained 56 (22 women) NGO animators on the use of public services and advocacy.
BCC INDICATORS							
Indicator BCC.a: # targeted public health providers trained in BCC techniques in malaria prevention and control <i>Data are disaggregated by gender and by paid public health providers and community volunteer health agents.</i>	661	88 (33 women)	507 41 paid public health workers (7 women) 466 CHWs (46 women)	704 (156 women) Among whom 646 (148 women) public paid health workers, 44 (6 women) private facility workers; 14 (2 women) CHW and 13 (3 women)	433 (158) women) among whom 272 (129 women) paid public health workers; 49 (13 women) private facility workers; 112 (16 women) CHWs		During this quarter, the project trained a total of 272 public health workers: 49 private health workers; 112 CHWs in BCC techniques in malaria prevention and control.

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 Actual	FY14-Q2 Actual	FY14-Q3 Actual	FY14-Q4 Actual	FY14 Annual Target	Notes
Indicator BCC.b: # people from NGOs sub grantees and CBOs trained in BCC techniques in malaria prevention and control <i>Data are disaggregated by gender and regions</i>	N/A	22 (3 women)	31 (5 women)	0	11 (1 woman)	50	The project trained 11 animators during the CHWs training in Conakry (4) and in Boké (7).
Indicator BCC.c: # people reached by NGOs and CHWs BCC malaria prevention and control activities <i>Data are disaggregated by gender and by region</i>	N/A	346,232 Boké: 82,315 Faranah: 24,122 Kindia: 100,951 Labé: 138,844	716,552 (437,940 women)	234,778 (131,794 women)	227,736 (128,982 women)	943,200	<p>During this quarter, 227,736 people (128,982 women) were reached by BCC activities.</p> <p>Of this total, 198,385 people (111,361 women) reached by CHWs during home visits and</p> <p>29,351 (17,621 women) reached by NGO facilitators during group discussions: The regional breakdown is presented in the narrative.</p>
Indicator BCC.d: % of people who recall hearing or seeing a specific malaria message	The Baseline data of this indicator will be measured during the KAP survey planned in December 2013.	N/A			NA	30%	This indicator was collected by the KAP survey conducted by the project during the past quarter. We expect to receive the report by December 2014.

Indicator	Baseline (or RTI Achievement through <i>Faisons Ensemble</i> if applicable)	FY14-Q1 <i>Actual</i>	FY14-Q2 <i>Actual</i>	FY14-Q3 <i>Actual</i>	FY14-Q4 <i>Actual</i>	FY14 <i>Annual Target</i>	Notes
<p>Indicator BCC: # BCC products produced and disseminated with project support during the reporting period</p> <p><i>Data are disaggregated by media type.</i></p>	23 (Pamphlet, 3; Radio Spots, 5; Radio Programs, 10; TV, 5)	4 Spots radio broadcasted, 4 SMS messages disseminated, 8,170 T-shirt, 4,000 bags, 4,100 caps and 351 banners.	2 spots radio and TV produced. These spots have been broadcasted 1,033 times through radios and 121 times though TV. 3 round tables produced and broadcast 11 times, 3,505 Tee-shirt, 1,265 caps, 1,126 bags and 160 banners produced and distributed..	2 new spots (radio and TV) were produced for the distribution campaign in Conakry. These spots plus the existing spots have been broadcast 1,436 times through radio stations and 138 times though TV. 2 roundtables produced and broadcast 10 times. 5 interactive programs produced and broadcast 25 times, 3,555 tee-shirt, 1,500 posters and 260 banners also produced and distributed	2 pots (radio and TV) produced for the correct and regular use of LLINs have been broadcast 1,845 times through radio stations and 192 times though TV. 2 interactive programs produced and broadcasted during the reporting quarter		Using these channels, the project disseminated key messages on distribution, regular, correct use of LLINs and also promotion of early care seeking.